NOTICE OF PROPOSED RULEMAKING

TITLE 20. COMMERCE, PROFESSIONS, AND OCCUPATIONS

CHAPTER 6. DEPARTMENT OF INSURANCE

PREAMBLE

1.	**Sections Affected**	**Rulemaking Action**
	R20-6-201	Amend
	R20-6-201.01	New Section
	R20-6-201.02	New Section
	R20-6-202	Amend
	R20-6-203	New Section
	R20-6-204	Amend
	R20-6-205	Renumber
	R20-6-205	Amend
	R20-6-206	Renumber
	R20-6-206	Amend
	R20-6-207	Renumber
	R20-6-207	Amend
	R20-6-208	Renumber
	R20-6-208	Amend
	R20-6-209	Renumber
	R20-6-209	Amend
	R20-6-210	Renumber

R20-6-210	Amend
R20-6-211	Renumber
R20-6-211	Amend
R20-6-212	Renumber
R20-6-212	Amend
R20-6-212.01	Renumber
R20-6-212.01	Amend
R20-6-213	Renumber
R20-6-213	Amend
R20-6-214	Renumber
R20-6-214	Amend
R20-6-215	Renumber
R20-6-215.01	Renumber
R20-6-216	Renumber
R20-6-217	Renumber

2. The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

Authorizing statute: A.R.S. §§ 20-143

Implementing statutes: A.R.S. **§§** 20-201.07, 20-442, 20-443, 20-444, 20-445, 20-448, 20-449, 20-452, 20-826(T), 20-1018, 20-1057(X), 20-1110(E)

3. The list of all previous notices appearing in the Register addressing the proposed rules:

Notice of Rulemaking Docket Opening: 12 A.A.R. 358, February 3, 2006

4. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name: Margaret McClelland

Address: Arizona Department of Insurance

2910 N. 44th Street, Suite 210

Phoenix, Arizona 85018

E-mail: MMcClelland@id.state.az.us

Telephone Number: (602) 364-3471

Fax Number: (602) 364-3470

5. An explanation of the rules, including the agency's reasons for initiating the rules:

This rulemaking repeals obsolete rules, improves clarity, conciseness, and understandability of all rules that are not being repealed and makes the rule consistent with statutory changes and model regulations of the North American Insurance Commissioners. New definitions are added to R20-6-201 to define terms used in this Article. Current Sections are revised and new Sections are added to clarify requirements regarding advertisement, requiring insurers to provide an English translation of documents filed in a foreign language. The changes to the advertising rules are due to Laws 2000, Ch. 37, which eliminated the Department's prior review and approval of insurers' advertising materials. The Department proposes a new rule to specify the procedures for filing advertising materials and to facilitate the Department's timely review of filed materials. The new rule requiring

translations will permit the Department to conduct required reviews of rules and forms.

6. A reference to any study relevant to the rules that the agency reviewed and either proposes to rely on in its evaluation of or justification for the rules or proposes not to rely on in its evaluation of or justification for the rules, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

None

7. A showing of good cause why the rules are necessary to promote a statewide interest if the rules will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

8. The preliminary summary of the economic, small business, and consumer impact:

The portions of this rulemaking that repeal or amend existing rules will have intangible benefits for the consumers by repealing obsolete provisions that might otherwise be confusing and simplifying the text of the remaining rules.

The new Section, R20-6-203, requiring insurers to provide the Department with English translations of foreign documents may pose some costs on insurers, although the Department believes that the insurers likely have such translations available, they simply have not previously been required to file them. Any cost to insurers is outweighed by the benefit to the insurance buying public by permitting

the Department to conduct adequate regulatory review of documents written in a foreign language.

The Department is not aware of small businesses that will be directly impacted by this rulemaking, therefore, the Department does not believe it is necessary to reduce the impact on small businesses.

The Department does not expect economic impacts to the Department or other governmental agencies

9. The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:

Name: Margaret McClelland

Address: Arizona Department of Insurance
2910 N. 44th Street, Suite 210
Phoenix, Arizona 85018

Telephone Number: (602) 364-3471

Fax Number: (602) 364-3470

10. The time, place, and nature of the proceedings for the making, amendment, or repeal of the rules or, if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rules:

ADOI will hold an oral proceeding to receive public comments in accordance with A.R.S. § 41-1023 on September 26, 2006 at 10:00 am at the Arizona Department

of Insurance, 2910 North 44th Street, Phoenix Arizona, 3rd floor training room. ADOI will accept comments that are received by 5:00 p.m. on September 29, 2006 or that are postmarked by that date. The comment period will end and the record will close at 5:00 p.m. on September 29, 2006.

11. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

Not applicable

12. Incorporations by reference and their locations in the rules:

R20-6-212 and R20-6-212.01

13. The full text of the rules follows:

TITLE 20. COMMERCE, PROFESSIONS, AND OCCUPATIONS

CHAPTER 6. DEPARTMENT OF INSURANCE

ARTICLE 2. TRANSACTION OF INSURANCE

R20-6-201. Advertisements of ~~Disability~~ Health Insurance

R20-6-201.01. Insurer Advertising Responsibility and Records

R20-6-201.02. Procedures for Filing Advertising Materials; Transmittal Form

R20-6-202. Advertising, Solicitation, and Transaction of Life Insurance

R20-6-203. ~~Repealed~~ Form Filings; Translations

R20-6-204. Surplus Lines Brokers' Filing Requirements; List of Unauthorized Insurers

~~R20-6-206.~~R20-6-205. ~~Repealed~~ Local or Regional Retaliatory Tax Information

~~R20-6-207.~~R20-6-206. Industrial Insureds

~~R20-6-208. Expired~~

~~R20-6-209.~~R20-6-207. ~~Unfair Sex~~ Gender Discrimination

~~R20-6-210.~~R20-6-208. ~~Expired~~ Group Coverage Discontinuance and Replacement

~~R20-6-211.~~R20-6-209. Life Insurance Solicitation

~~R20-6-212.~~R20-6-210. Readable and Understandable Policy: Private Passenger Automobile, Homeowner, Personal Line Dwelling, and Mobile Homeowner

~~R20-6-213.~~R20-6-211. ~~Unfair~~ Discrimination on the Basis of Blindness, Partial Blindness

~~R20-6-215.~~ R20-6-212.	Forms for Replacement of Life Insurance Policies and Annuities
~~R20-6-215.01.~~R20-6-212.01.	Forms for Buyer's Guide for Annuities
~~R20-6-216.~~R20-6-213.	Life and Disability Insurance Policy Language Simplification
~~R20-6-217.~~R20-6-214.	~~Expired~~ Coordination of Benefits

TITLE 20. COMMERCE, PROFESSIONS, AND OCCUPATIONS

CHAPTER 6. DEPARTMENT OF INSURANCE

ARTICLE 2. TRANSACTION OF INSURANCE

R20-6-201. Advertisements of ~~Disability~~ Health Insurance

A. Definitions. The following definitions apply to this Section and to R20-6-201.01, R20-6-201.02, and R20-6-203:

~~1. "An advertisement for the purpose of these rules shall include:~~

1. "Advertisement" means materials and information used by an insurer to generate insurance business.

a. Advertisement includes the following information:

~~a~~i. Printed and published material, audio visual material, or other forms of electronic communication that ~~and descriptive literature of~~ an insurer ~~used~~ uses or displays in direct mail, newspapers, magazines, radio, ~~and TV scripts,~~ television, billboards, internet web sites, and similar ~~displays~~ media to inform the public about the insurer or its products; ~~and~~

~~b~~ii. Descriptive literature and sales aids ~~of all kinds issued by~~ an insurer issues, or releases for presentation to members of the public, including ~~but not limited to~~ circulars, leaflets, booklets, depictions, illustrations, and form letters; ~~and~~

~~c~~iii. Prepared sales talks~~,~~ and presentations and material for use by an insurer or prepared by an insurer for use by authorized ~~agents and~~

~~brokers~~ producers; and~~, and representations made by agents and brokers in accordance therewith~~.

iv. Material included with a policy when the policy is delivered and material used in the solicitation of renewals and reinstatements;

b. "Advertisement" does not include the following:

i. Material used solely for training and educating an insurer's employees or producers;

ii. Material used in-house by insurers;

iii. Communications within an insurer's own organization not intended for dissemination to the public;

iv. Individual communications of a personal nature with current policy holders other than material urging the policyholders to increase or expand coverages;

v. Correspondence between a prospective group or blanket policyholder and an insurer in the course of negotiating a group or blanket contract;

vi. Court-approved material ordered by a court to be disseminated to policyholders;

vii. Material in which only the name of the insurer is displayed, in connection with promotion or sponsorship of a charitable event; or

viii. A general announcement from a group or blanket policyholder to eligible individuals on an employment or membership list that a contract or program has been written or arranged. The

announcement shall clearly indicate that it is preliminary to the issuance of a booklet, and that the announcement does not describe the specific benefits under the contract or program, nor the advantages as to the purchase of the contract or program. A general announcement does not prohibit a general endorsement of the program by the sponsor.

ix. Health and wellness material with general health and wellness information.

2. "Disability insurance" has the same meaning prescribed in A.R.S. § 20-253.

3. "Elimination period" means the time between the date a loss occurs and the date that benefits begin to accrue for that loss.

4. "Exclusion" means a policy term stating a risk that an insurer has not assumed.

5. "Health insurance" means:

a. Disability insurance;

b. Insurance provided by a service corporation regulated under A.R.S. § 20-821 et seq.;

c. Insurance provided by a prepaid dental plan organization regulated under A.R.S. § 20-1001 et seq.; and

d. Insurance provided by a health care services organization regulated under A.R.S. § 20-1051 et seq.

6. "Insurance administrator" or "administrator" has the meaning prescribed in A.R.S. § 20-485(A)(1).

7. “Insurer” has the same meaning prescribed in A.R.S. § 20-104.

8. “Limitation” means a policy term, other than an exclusion or reduction, that decreases the risk assumed by the insurer or the insurer’s obligation to provide benefits.

9. “Person” has the meaning in A.R.S. § 20-105.

~~2.~~10. "Policy" ~~for the purpose of these rules shall include~~ means any ~~policy,~~ plan, certificate, contract, agreement, statement of coverage, evidence of coverage, subscription contract, membership coverage, rider, or endorsement ~~which~~ that provides disability benefits, health insurance, ~~or~~ medical, surgical or hospital expense benefits, long-term care benefits, or Medicare supplement benefits ~~whether on~~ in the form of a cash indemnity, reimbursement, or service ~~basis, except when other than life, and except disability and double indemnity benefits included in life insurance and annuity contracts~~.

11. “Reduction” means a policy term that reduces the amount of an insured’s benefits. A reduction means that the insurer has assumed the risk of a particular loss, but the amount or period of the insurer’s coverage is less than what the insurer would have paid for the loss without the reduction.

12. "Spokesperson" means a person making a testimonial about or endorsement of an insurer's product who:

a. Has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee, or independent contractor;

b. Has been formed by the insurer, is owned or controlled by the insurer, its employees, or a person who owns or controls an insurer;

c. Is in a policy-making position who is affiliated with the insurer in any capacity described in subsections (a) or (b); or

d. Is in any way directly or indirectly compensated for making a testimonial or endorsement, except where the sole financial interest or compensation of a spokesperson, for all testimonials or endorsements made on behalf of the insurer, consists of the payment of union scale wages required by union rules, and if the payment is actually the scale for television or radio performances.

~~3. "Insurer" for the purpose of these rules shall include any individual, agent, broker, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyd's, fraternal benefit society, and any other legal entity engaged in the advertisement of a policy as herein defined.~~

~~B. Advertisements in general. Advertisements shall be truthful and not misleading in fact or in implication. Words or phrases, the meaning of which is clear only by implication or by familiarity with insurance terminology.~~

~~C. Advertisements of benefits payable, losses covered or premiums payable~~

~~1. Deceptive words, phrases or illustrations -- Words, phrases or illustrations shall not be used in a manner which misleads or has the capacity and tendency to~~

~~deceive as to the extent of any policy benefit payable, loss covered or premium payable. An advertisement relating to any policy benefit payable, loss covered or premium payable shall be sufficiently complete and clear as to avoid deception or the capacity and tendency to deceive.~~

~~a. Explanation:~~

B. Scope.

1. This Section applies to all advertisements for health insurance.

2. This Section applies to the conduct of insurers, producers, and third-party administrators.

C. General requirements. Health insurance advertisements shall meet the requirements of this Section.

1. Advertisements shall be truthful and not misleading. The insurer shall not use words or phrases, the meaning of which is clear only by implication or by familiarity with insurance terminology.

2. An advertisement shall not omit information or use words, phrases, statements, references, or illustrations if the omission of information or use of words, phrases, statements, references, or illustrations has the capacity to mislead or deceive purchasers or prospective purchasers.

~~i.~~3. The words and phrases used to describe a policy shall accurately describe the benefits of the policy and shall not exaggerate any benefit beyond the policy terms through the use of phrases such as ~~the~~ "all," "full," "complete,"comprehensive,"unlimited," "up to," "as high as," "this policy will pay your hospital and surgical bills" or "this policy will replace your

income," or similar words and phrases ~~shall not be used so as to exaggerate any benefit beyond the terms of the policy but may be used only in such manner as fairly to describe such benefit~~.

~~ii.~~4. ~~A~~ If a policy ~~covering~~ covers only ~~1~~ one disease or a list of specified diseases, any advertisement for the policy shall not ~~be advertised so as to~~ imply coverage beyond the ~~terms of the policy. Synonymous~~ specified diseases. ~~terms shall not be used to refer to any disease so as to~~ that ~~imply broader coverage than is the fact~~.

~~iii.~~5. ~~The benefits of~~ If a policy ~~which~~ pays varying amounts for the same loss occurring under different conditions or ~~which~~ pays benefits only when a loss occurs under certain conditions, any advertisement for the policy shall ~~not be advertised without disclosing~~ disclose the limited conditions ~~under which the benefits referred to are provided by the policy~~.

~~iv.~~6. ~~Phrases such as "this policy pays $1,800~~ If an advertisement specifies payment of a particular dollar amount for hospital room and board expenses,~~"~~ the advertisement shall also include ~~are incomplete without indicating~~ the maximum daily benefit and the maximum time limit for ~~hospital room and board~~ those expenses.

~~2.~~7. ~~Exceptions, reductions and limitations -- When an~~ An advertisement that refers to any dollar amount, period of time for which ~~any~~ a benefit is payable, cost of policy, or specific policy benefit or the loss for which ~~such~~ a benefit is payable~~, it~~ shall also disclose any related exclusions ~~those exceptions~~, reductions, and limitations ~~affecting the basic provisions of the~~

~~policy~~ without which the advertisement would have the capacity and tendency to mislead or deceive.

~~a. Explanation:~~

~~i. The term "exception" shall mean any provision in a policy whereby coverage for a specified hazard is entirely eliminated; it is a statement of a risk not assumed under the policy.~~

~~ii. The term "reduction" shall mean any provision which reduces the amount of the benefit; a risk of loss is assumed but payment upon the occurrence of such loss is limited to some amount or period less than would be otherwise payable had such reduction clause not been used.~~

~~iii. The term "limitation" shall mean any provision which restricts coverage under the policy other than an exception or a reduction.~~

~~iv.~~8. ~~Waiting, elimination, probationary or similar periods -- When a policy contains a time period between the effective date of the policy and the effective date of coverage under the policy or a time period between the date a loss occurs and the date benefits begin to accrue for such loss,~~ ~~an~~ ~~An advertisement covered by (C)(2) shall disclose the existence of such any waiting or elimination periods.~~ An advertisement shall disclose the existence of a waiting period if a policy contains a period between the effective date of the policy and the effective date of coverage under the policy. The advertisement shall disclose the existence of an elimination

period if there is a period between the date a loss occurs and the date benefits begin to accrue for loss.

~~3. Pre-existing conditions~~

~~a.~~9. An advertisement ~~covered by (C)(2)~~ shall disclose ~~the extent to which any loss is not covered if the cause of such loss is traceable to a condition existing prior to the effective date of the policy~~ any exclusion, reduction, or limitation applicable to a pre-existing condition; however, an insurer is not required to make disclosure in any advertisement that does not reference any specific product information, benefit level, or dollar amounts.

~~b.~~ 10. ~~When~~ If a policy ~~does not cover losses traceable to~~ has an exclusion, reduction, or limitation applicable to a preexisting ~~conditions~~ condition, ~~no~~ an advertisement ~~of the policy~~ shall not state or imply that the applicant's physical condition or medical history will not affect the issuance of the policy or payment of a claim, ~~thereunder. This limits the~~ including use of the phrase "no medical examination required" ~~and~~ or other similar phrases ~~of similar import~~.

11. ~~Necessity for disclosing policy provisions relating to renewability, cancellability and termination -- An~~ If an advertisement ~~which~~ refers to renewability, cancellation, or termination of a policy, or ~~which~~ states or illustrates time or age in connection with eligibility of applicants or continuation of the policy, the advertisement shall disclose the provisions relating to renewability, ~~cancellability~~ cancellation, and termination and

any modification of benefits, losses covered, or premiums because of age or for other reasons, in a manner ~~which~~ that shall not minimize or ~~render~~ obscure the qualifying conditions.

12. An advertisement shall not make any offer prohibited under A.R.S. § 20-452(4).

13. An advertisement shall not advertise any health insurance policy or form that has not been approved by the Department, unless the policy or form being advertised is exempt from approval or not subject to approval by order or statute.

14. An advertisement shall not state or imply that a product being offered is an introductory, special, or initial offer that will entitle the applicant to receive advantages not described in the policy by accepting the offer.

15. An advertisement designed to produce leads either by use of a coupon, a request to write or call the company, or subsequent advertisement before contact, shall disclose that a producer may contact the potential applicant.

~~E.~~**D.** Method of disclosure of required information. ~~—~~ ~~All information~~ If an insurer is required to disclose particular information, that information ~~required to be disclosed by these rules~~ shall be ~~set out conspicuously~~ conspicuous and in close ~~conjunction with~~ proximity to the statements to which ~~such~~ the information relates, or under ~~appropriate~~ a prominent ~~captions~~ caption ~~of such prominence~~ so that ~~it shall~~ the required disclosure is not ~~be~~ minimized, ~~rendered obscure~~ obscured, ~~or~~ presented in an ambiguous fashion, or intermingled with the ~~context~~ content of the advertisement ~~so as to be confusing or misleading~~.

~~F~~**E.** Testimonials. ~~–~~

1. Testimonials used in advertisements ~~must~~ shall be genuine, represent the current opinion of the author, be applicable to the policy advertised, and be accurately reproduced. The insurer shall provide the Department with the full name of the author and a copy of the full testimonial. ~~The~~ If an insurer~~, in using~~ uses a testimonial, the insurer adopts ~~makes as its own all of~~ the statements ~~contained therein~~ in the testimonial as the insurer's own statements ~~and the advertisement including such statements is subject to all of the provisions of these rules~~. If a testimonial or endorsement is used more than one year after it is given, the insurer shall obtain a confirmation from the author that the testimonial represents the current opinion of the author.

2. The insurer shall disclose the fact of a financial interest or the proprietary or representative capacity of a spokesperson in an advertisement in the introductory portion of the testimonial or endorsement in the same form and with equal prominence. If a spokesperson is directly or indirectly compensated for making a testimonial or endorsement, the insurer shall disclose that fact in the advertisement by language that states, "Paid Endorsement," or words of similar import in type, style, and size at least equal to that used for the spokesperson's name or the body of the testimonial or endorsement, whichever is larger. In the case of television or radio advertising, the insurer shall place the required disclosure prominently in the introductory portion of the advertisement.

~~G.~~**F.** ~~Use of statistics~~ Statistics. ~~--~~ An advertisement ~~relating to~~ with information on the dollar amounts of claims paid, the number of persons insured, or similar statistical information relating to any insurer or policy shall not use irrelevant facts and shall ~~not be used unless it~~ accurately ~~reflects~~ reflect all of the relevant facts specific to the advertised policy, or insurer. ~~Such an~~ An advertisement shall not state or imply that ~~such~~ statistics are derived from the policy being advertised unless ~~such~~ that is the fact. The insurer shall identify in the advertisement the source of any statistics used.

~~H.~~**G.** Inspection of policy. ~~--~~ An offer in an advertisement of free inspection of a policy or offer of a premium refund ~~is~~ does not ~~a~~ cure ~~for~~ misleading or deceptive statements ~~contained~~ in ~~such~~ the advertisement.

~~I.~~ **H.** Identification of plan or number of policies.

1. ~~When~~ If an advertisement offers a choice ~~of~~ in the amount of benefits ~~is referred to, an~~ the advertisement shall disclose that the amount of benefits ~~provided~~ depends ~~upon~~ on the ~~plan~~ policy selected and that the premium will vary with the amount of the benefits.
2. ~~When~~ If an advertisement refers to ~~various~~ benefits ~~which may be~~ contained in ~~2 or~~ more than one ~~policies~~ policy, other than a group master ~~policies~~ policy, the advertisement shall disclose that ~~such~~ the benefits are provided only ~~through a combination of such~~ if multiple policies are purchased.

~~J.~~ **I.** Disparaging comparisons and statements. ~~--~~ An advertisement shall not ~~directly or indirectly~~ make unfair, ~~or~~ incomplete, or unsubstantiated comparisons of other

insurers' policies or benefits or ~~otherwise~~ falsely disparage ~~competitors, their~~ other insurers' policies, services, or business methods. A comparison is unsubstantiated if the insurer has no empirical study, analysis, or documentation supporting the comparative statement or comparison of policies or benefits.

~~**K.**~~**J.** Jurisdictional ~~licensing~~ limits.

~~1. An~~ If an insurer has an advertisement ~~which is intended~~ that is meant to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed, the advertisement shall ~~not imply licensing beyond those limits.~~

~~2. Such advertisements by direct mail insurers shall~~ indicate that the insurer is licensed in a specified state or states only, or is not licensed in a specified state or states, by use of ~~some~~ language such as "This Company is licensed only in State A" or "This Company is not licensed in State B."

~~**L.**~~**K.** Identity of insurer. ~~-- The identity of the insurer shall be made clear in all of its advertisements. An advertisement shall not use a trade name, service mark, slogan, symbol or other device which has the capacity and tendency to mislead or deceive as to the true identity of the insurer.~~ The insurer shall state the name of the actual insurer in all of its advertisements. An advertisement shall clearly identify the insurer and shall not use a trade name, an insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol, or other device ~~which has the capacity and tendency to~~ that may mislead or deceive the public as to the ~~true~~ insurer's identity ~~of the insurer~~.

~~**M.**~~**L.** Group ~~or quasi-group implications –~~ insurance. An advertisement ~~of a particular policy~~ shall not state or imply that prospective policyholders become group or quasi-group members and ~~as such~~ enjoy special rates or underwriting privileges, unless ~~such is the~~ supported by fact. An advertisement to join an association, trust, or group that is also an invitation to contract for insurance coverage shall disclose that the applicant will be purchasing both membership in the association, trust, or group and insurance coverage.

~~**N.** Introductory, initial or special offers -- An advertisement shall not state or imply that a particular policy or combination of policies is an introductory, initial, or special offer and that the applicant will receive advantages by accepting the offer, unless such is the fact.~~

~~**O.** Approval or endorsement by third parties~~

~~**1.**~~**M.** Government approval. An advertisement shall not state or imply ~~that~~ any of the following:

1. ~~an~~ That a governmental agency or regulator is connected with or has provided or endorsed a policy or endorsed an insurer ~~or a policy~~;
2. That a governmental agency or regulator has examined ~~been approved or~~ an insurer's financial condition ~~has been examined~~ and found ~~to be~~ it satisfactory ~~by a governmental agency, unless such is the fact.~~ This subsection does not apply if an insurer is responding to a specific documented, public, false allegation about its financial condition.

~~2.~~**N.** Endorsements. An advertisement ~~shall not~~ may state ~~or imply~~ that ~~an insurer or a policy has been approved or endorsed by any~~ an individual, group ~~of individuals~~,

society, association, or other organization has approved or endorsed the insurer or its policy, unless such is the fact if the organization or group has actually done so in writing and if any proprietary relationship between the organization and the insure is disclosed.

P. O. Service facilities – Claims handling. An advertisement shall not contain untrue false statements with respect to about the time within which claims are paid or statements which that imply that claim settlements will be liberal or generous beyond the terms of the policy.

Q. P. Statements about an the insurer.— An advertisement shall not contain false or misleading statements which are untrue in fact or by implication misleading with respect to the about an insurer's assets, corporate structure, financial standing, age length of time in business, or relative position in the insurance business.

R. Special enforcement procedures

1. Advertising file -- Each insurer shall maintain at its home or principal office a complete file containing every printed, published, recorded, or prepared advertisement of individual policies and typical printed, published, recorded, or prepared advertisements of blanket, franchise, and group policies hereafter disseminated in this or any other state whether or not licensed in such other state, with a notation attached to each such advertisement which shall indicate the manner and extent of distribution and the form number of any policy advertised. Such file shall be subject to regular and periodical inspection by this Department. All such

~~advertisements and shall be maintained in said file for a period of not less than 3 years.~~

~~2. Certificate of compliance -- Each insurer required to file an annual statement, which is now or which hereafter becomes subject to the provisions of this rule, must file with this Department, together with its annual statement, a certificate executed by an authorized officer of the insurer wherein it is stated that, to the best of his knowledge, information and belief, the advertisements which were disseminated by the insurer during the preceding statement year complied, or were made to comply, in all respects with the provisions of the insurance laws of this state as implemented and interpreted by this rule.~~

~~3. Acknowledgment -- It is requested that the chief executive officer of each insurer to which this rule is addressed acknowledge its receipt and indicate its intention to comply therewith.~~

R20-6-201.01. Insurer Advertising Responsibility and Records

A An insurer shall establish, and at all times maintain, a system of control over the content, form, and method of dissemination of all advertisements of its policies. The insurer whose policies are advertised is responsible for the advertisements, regardless of who writes, creates, designs, or presents the advertisement, except the insurer is not responsible for any advertisement placed by a person to whom the insurer gave no actual or apparent authority. Before using an advertisement

about an insurer or its products, a producer shall get written approval from the insurer for use of the advertisements that were not supplied by the insurer.

B An insurer shall maintain, at its home or principal office, the following:

1. Advertisements disseminated by the insurer in Arizona or any other state, including:
   a. Each printed, published, recorded, or prepared advertisement of individual policies; and
   b. Typical printed, published, recorded, or prepared advertisements of blanket, franchise, and group policies.
2. A notation attached to each advertisement specifying the manner and extent of distribution and the form number of any policy advertised, and
3. Documentation supporting any testimonials, statistical claims, or comparisons shown in the advertising.

C. An insurer shall maintain the advertisements, notations, and supporting documentation for at least three years from the date of first dissemination.

R20-6-201.02. Procedures for Filing Advertising Materials; Transmittal Form

A. An insurer that is required to file a health insurance advertisement with the Department as specified in A.R.S. §§ 20-826(T), 20-1018, 20-1057(X), 20-1110(E), and 20-1662 shall file the advertisement with a transmittal form prescribed by the Department.

B. The transmittal form shall include the following information:

1. Identifying information of the insurer, including name, address, National Association of Insurance Commissioners' identification number, and type of insurer;

2. A contact person at the insurer with whom the Department can communicate about the advertisement;

3. Description of the type of advertisement being filed;

4. Planned use and dissemination of the advertisement, including date of first use, or a statement that the advertisement will not be used any earlier than a specified date;

5. Description of product being advertised;

6. Form number and name for the advertised product; and

7. A certification from a officer of the insurer that the advertisement complies with applicable laws; and

8. The dated signature of the insurer's officer.

R20-6-202. Advertising, Solicitation, and Transaction of Life Insurance

~~**A.** Authority and purpose -- This rule is adopted by the Director of Insurance pursuant to the rulemaking power of A.R.S. § 20-143, subject to the provisions of A.R.S. §§ 41-1001 through 41-1008. It is the purpose of this rule to implement the administration of the Arizona Insurance Code by defining acts and practices which are contrary to or would violate various sections of the Insurance Code, including but not limited to Title 20, Chapter 2, Articles 1, 2, 3 and 6, Chapter 5, Article 1 and Chapter 6, Article.~~

A. The definitions in R20-6-201(A) and the following definition apply in this Section:

"Life insurance" means a life insurance contract, including all benefits payable under the policy.

B. Applicability

1. This ~~rule shall apply~~ Section and R20-6-201 apply to:

   a. ~~To any insurance company, agent, person, broker, or solicitor, as those terms are defined in the Insurance Code~~ All persons subject to regulation under A.R.S. Title 20;

   b. ~~To acts and practices in the advertising~~ Advertising, promotion, solicitation, negotiation, ~~or effecting the~~ and sale of life insurance policies, regardless of the form of dissemination~~;~~.

   ~~c. To such acts and practices, whether they involve the use of language disseminated by means of sales kits, policy jackets or covers, letters, personal presentations, visual aids, or other sales media.~~

2. This rule ~~shall~~ does not apply to group insurance, franchise insurance, or to annuities without life contingencies.

C. ~~Policy~~ General provisions.

~~Misleading, through omissions, use of irrelevant material, or improper emphasis~~

~~The purpose of this rule essentially is to assure the fair disclosure of relevant facts in the sale of life insurance. As used herein, the words "life insurance" shall mean the entire life insurance contract, including all benefits provided therein, and are not intended to be limited to the benefits payable on death. It is also designed to protect purchasers and prospective purchasers of life insurance policies against~~

~~the use of sales methods which are misleading because of~~ A life insurance advertisement shall not mislead the public by:

a. ~~Omission of~~ Omitting information that ~~facts~~ fairly ~~describing~~ describes both the subject matter as a life insurance policy and the benefits ~~obtainable thereunder~~ available under the policy; ~~or~~

b. ~~An~~ Placing undue emphasis ~~upon~~ on facts ~~which~~ that, however true, are not relevant to the sale of life insurance; or

c. ~~An~~ Placing undue emphasis ~~upon~~ on features ~~which are~~ of incidental or secondary importance to the life insurance aspects of the policy.

~~2. In considering possible the Department of Insurance will consider as relevant to a proposed sale, statements which are intended to:~~

~~a. Motivate the insured to purchase life insurance; or~~

~~b. Provide an explanation of the benefits provided by the life insurance policy; or~~

~~c. Present a picture of the company's ability to conduct a life insurance business.~~

~~3. Specified acts and practices -- To assure such fair disclosure and to prevent the use of misleading sales methods, this rule provides advance interpretations as to the specific acts and practices which the Department of Insurance believes constitute a violation of such statutes; provided, however, it is recognized that whether particular conduct comes within the prohibition of such statutory provisions depends on the facts in each case.~~

~~4. Acts and practices not specified -- Although this rule is intended to cover selected acts and practices which have been of serious concern to the Department of Insurance, this delineation is not a determination that any act of practice not specified herein is in conformance with the statutes. However, this rule will be read as a guide in considering whether any unspecified act or practice is of the kind or character which may be within the prohibitions of the statute and this rule.~~

D. ~~Prohibited acts and practices.~~ The following acts are deemed misleading and deceptive:

1. ~~References to profits and investments -- In accordance with the authority, applicability and policy set out in subsections (A) through (C) above, the following is declared to be a violation of this rule:~~ ~~The~~ Using any statement, including ~~use of the word or words~~ phrases such as "investment," "investment plan," "founders plan," "charter plan," expansion plan," "profit," "profits," or "profit sharing," in a context or under ~~such~~ circumstances or conditions ~~as to have the capacity and tendency to~~ that may mislead a purchaser or prospective purchaser to believe that ~~he will receive~~ the insurer is selling something other than a life insurance policy, or will provide some benefit not ~~provided~~ included in the policy, or ~~some benefit not~~ available to other persons of the same class and equal expectation of life. ~~This is not intended to prohibit appropriate presentation of the investment elements of a life insurance policy.~~

2. ~~Other limitations -- In accordance with subsections (A) through (C) above, the acts and practices set out in the following paragraphs are declared to be a violation of this rule in the sale of life insurance when used in a context or done under such circumstances or conditions as to have the capacity or tendency to mislead a purchaser or prospective purchaser to believe that he will receive, or that it is probable he will receive, something other than a life insurance policy, some benefit not provided in the policy, or some benefit not available to other persons of the same class and equal expectation of life. Each of said paragraphs will, therefore, be construed and applied in accordance with the provisions of this Section.~~

~~a.~~ Using any phrase as the name or title of a life insurance policy ~~which~~ if the phrase does not include the words "life insurance," unless ~~accompanied by~~ other language in the same document ~~clearly indicating~~ expressly provides that the contract ~~referred to~~ is a life insurance policy.

~~b.~~3. Making any statement relating to the growth or earnings of the life insurance industry or to the tax status of life insurance companies in a context ~~which~~ that would reasonably be understood to interest a prospect in the purchase of shares of stock in the insurance company rather than in the purchase of a life insurance policy.

~~c.~~4. Making any statement ~~which~~ that reasonably gives rise to the belief that the insured will enjoy a status common to a stockholder or will acquire a stock ownership interest in the insurance company by ~~virtue of the purchase of~~ purchasing the policy, unless ~~such~~ the statement is made with reference to

policies of domestic life insurers engaged in a program ~~as set forth in the provisions of~~ allowed under A.R.S. § 20-453.

~~d.~~5. Providing a policyholder with ~~any~~ a premium receipt book, policy jacket, return envelope, or other printed or electronic material ~~containing references to the company's~~ referring to the insurer's "investment department," "insured investment department," or similar terminology in such a manner as to imply that the policy is sold, ~~or~~ issued, or ~~is~~ serviced by the insurer's investment department ~~of an insurance company~~.

~~3. Referenced to special benefits~~

~~a.~~6. Making any statement ~~which~~ that reasonably tends to imply that, by purchasing a policy, the purchaser or prospective purchaser will become a member of a limited group of persons who may receive the payment of dividends, special advantages, benefits, or favored treatment unless ~~such is specifically provided in~~ the insurance contract specifically provides for the described treatment. ~~This paragraph has no relation or applicability to policies under which insured persons of 1 class of risk may receive dividends of a higher rate than persons of another class of risk.~~

~~b. Stating that each stockholder is given the right to purchase or allocate a specific number of policies.~~

~~c.~~7. Stating or implying that only a limited number of persons or limited class of persons ~~will be eligible to~~ may buy a particular kind of policy, unless ~~such~~ the limitation is related to recognized underwriting practices, or ~~unless such limitation~~ is specifically stated in the policy or rider ~~therefore~~.

~~d. Stating that the policyholders who are to act as "centers of influence" for an insurance company in that capacity will share in the company's surplus earnings in some manner not available to other policyholders of the same class.~~

~~4. Coupons~~

~~a. Stating or implying that the principal amounts payable under the coupons represent interest, earnings, return on investments, a bonus, or anything other than benefits, the cost of which is included in the total premium.~~

~~b.~~8. Describing premium payments in language ~~which~~ that states the payment is a "deposit," unless:

~~i.~~a. The payment establishes a debtor-creditor relationship between the insurance company and the policyholder; or

~~ii.~~b. The term is used ~~in conjunction~~ with the word "premium" in a manner as to clearly indicate the true character of the payment.

~~5.~~9. ~~References to dividends~~

~~a.~~ Providing any illustration or projection of future dividends ~~which~~ that is not based on the company's actual scale ~~being used by the company~~ for ~~the~~ payment of current dividends. ~~Furthermore, such~~ The projection or illustration ~~must~~ shall clearly indicate that the dividends are not guarantees.

~~b.~~10. Using the words "dividends," "cash dividends," "surplus," or similar phrases in ~~such~~ a manner as to state or imply that the payment of dividends is guaranteed or certain to occur.

~~c.~~11. Stating, without qualification, that a purchaser of a policy will share in a stated percentage or portion of the insurer's earnings ~~of the company~~.

~~d.~~ 12. Making any statement that projected dividends under a participating policy will be or can be sufficient at any future time to assure the receipt of benefits such as a paid-up policy without further payment of premiums unless the statement ~~is accompanied by an adequate explanation as to~~ also explains:

~~i.~~a. What benefits or coverage would be provided at ~~such~~ the future time; and

~~ii.~~b. Under ~~which~~ what conditions this would occur.

~~6. Miscellaneous~~

~~a.~~13. Describing a life insurance policy or premium payments ~~therefor~~ in terms of "units of participation," unless accompanied by other language clearly indicating the references are to a life insurance policy or to premium payments, as the case may be.

~~b. Using the words "contract," "contract plan," or "plan" in describing a life insurance policy, unless accompanied by other language in the same document clearly indicating the reference is to a life insurance policy.~~

~~c.~~14. ~~Including in sales kits and prepared sales presentations proposed answers to a prospect's question as to whether life insurance is being sold, which~~

~~are designed to avoid a clear and unequivocal statement that LIFE INSURANCE IS THE SUBJECT MATTER OF THE SOLICITATION~~. Advising producers to avoid disclosing that life insurance is the subject of the solicitation or sale.

~~d.~~15. Stating that an insured is guaranteed certain benefits if the policy is allowed to lapse, without ~~making an explanation of~~ explaining the non-forfeiture benefits.

~~e.~~16. Using a dollar amount in printed material to be shown to a prospective policyholder, unless the figure is accompanied by language ~~in such material~~ indicating the nature of the figure~~. (This is intended to prohibit~~ including the use of dollar figures not in relation to guaranteed values and properly projected dividend figures~~. It is intended to prohibit~~ and the use of figures showing growth of stock values, or other values not a part of the life insurance contract.~~)~~

~~f.~~17. Stating that a policy provides ~~certain~~ features ~~which are~~ not found in any other insurance ~~policies~~ policy, unless ~~that in fact be true~~ the insurer can demonstrate that other policies do not have the same feature.

~~g.~~18. ~~The making of~~ Making any statement or implication ~~in regard to~~ about an insurance policy that cannot be verified by reference to the policy contract itself, or a specimen copy of the policy being described, or to the company's officially published rate book and dividend illustrations.

~~h.~~19. Stating that life insurance is "loss proof" or "depression proof," but this shall not prohibit statements that life insurance benefits, ~~(~~other than

dividends~~),~~ are guaranteed by the company regardless of economic conditions.

~~i.~~20. Making any statement that a company makes a profit as a result of policy lapses or surrenders.

~~j.~~21. Making comparisons to the past experience of other life insurance companies as a means of projecting possible experience ~~of your company~~ for the company issuing the advertising. ~~This is intended to protect policyholders from being misled through presentations as to the probabilities of the policy being sold having the same results as that of other companies which successfully sold similar policies, without a fair disclosure of the fact that many companies have had unfavorable experience.~~

22. Conduct or statements designed to mislead a potential applicant or purchaser.

~~**E.** Effective date. The provisions of this rule shall become effective on January 1, 1969.~~

~~**F.** Severability clause. If any provision of this rule is held invalid, such invalidity shall not affect other provisions of this rule which can be given effect without the invalid provision.~~

~~**G.** Company responsibility. Each company will be held responsible for disseminating this information to their representatives and assuring compliance.~~

R20-6-203. ~~**Repealed**~~ **Form Filings; Translations**

A. An insurer or rate service organization or rating organization shall provide the Department of Insurance with an English language translation of each form, advertisement, or other document or material that the insurer is required by statute or rule to file with the Department, if the filed document or material is communicated in a language other than English

B. The translation shall compare the foreign language version in a side-by-side format with the English language translation and shall be performed by a person with formal college-level or specialized training in the foreign language including training in grammar and sentence syntax.

C. With each translation, the insurer shall also provide a sworn statement signed by the certified vendor or translator who translated the document. The sworn statement shall include the qualifications of the translator and shall attest that the translation is identical in substance to the English document or material.

D. If an insurer files a foreign language version of a document or material that the insurer has previously filed in English, the insurer is not required to refile the English version, but shall identify the English version, provide the mandatory side-by-side comparison under subsection (B), and shall file the sworn statement required under subsection (C).

R20-6-204. Surplus Lines Brokers' Filing Requirements; List of Unauthorized Insurers

A. Definitions.

1. "Listed insurer" means an unauthorized insurer who is on the list created by the Director under subsection (C)(1) and A.R.S. § 20-413.

2. "Surplus lines broker" means a person licensed under A.R.S. § 20-411.

3. "Surplus lines insurance" means the type of insurance described in A.R.S. § 20-407.

4. "Unauthorized insurer" means an insurer that does not have a certificate of authority to transact insurance in Arizona.

B. Filing requirements. ~~Unauthorized insurers~~ An unauthorized insurer writing surplus lines insurance in Arizona and each surplus line ~~brokers~~ broker shall comply with the filing requirements of this Section.

C. List of unauthorized insurers.

1. The Director shall create and maintain a list of unauthorized insurers that may write surplus lines insurance in this state under A.R.S. § 20-413. The list shall include the names of unauthorized insurers for which a surplus lines broker has made the filings required by this Section.

2. ~~A listed insurer shall remain~~ The Director shall retain a listed insurer on the list until:

   a. The Director removes the insurer from the list under A.R.S. § 20-413 or subsection (H) or (I) below~~,~~, or

   b. The insurer requests the Director to remove its name from the list, and the Director consents to the request.

D. Placing surplus lines insurance. A surplus lines broker shall restrict all surplus lines business placed by the surplus lines broker to listed insurers. An insurer's

removal from the list does not affect the validity of any contract existing at the time of removal.

E. Requirements for Initial Listing of Foreign Unauthorized Insurers and Insurance Exchanges. A surplus lines broker shall file the following documents for a foreign unauthorized insurer:

1. An original or a certified copy of the insurer's certificate of compliance from the supervisory official of the insurer's state of domicile;
2. A current Certificate of Deposit, Capital, and Surplus for Foreign Insurers from the public officials or other persons who have supervision over the insurer in any other state;
3. A certification from the surplus lines broker of the insurer's compliance with the financial requirements of A.R.S. § 20-413;
4. The insurer's most recent report of financial examination, certified by the insurance supervisory official of its state of domicile; and
5. A certified copy of a full size National Association of Insurance Commissioners (N.A.I.C.) convention blank annual statement (Form 2) for the insurer as of December 31 of the preceding year.

F. Requirements for Initial Listing of Alien Unauthorized Insurers. A surplus lines broker shall file a certification of the insurer's compliance with the financial requirements of A.R.S. § 20-413. For all alien insurers other than title insurers, the surplus lines broker may rely on the information contained in the most recent N.A.I.C. Financial Review of Alien Insurers as prima facie evidence of the insurer's compliance.

G. Filing Requirements to Maintain Listing. To ensure that a foreign or alien unauthorized insurer remains on the Director's list, a surplus lines broker shall file, before June 1 of each year:

1. A copy of a full-size National Association of Insurance Commissioners (N.A.I.C.) convention blank annual statement (Form 2) for the insurer, as of December 31 of the preceding year; and

2. An affidavit, on a form approved by the Director, that meets the requirements of this subsection.

    a. The surplus lines broker and a duly authorized officer of the unauthorized insurer shall sign the affidavit.

    b. The insurer's officer shall state whether there have been any changes in the insurer's name, address, state of domicile, statutory ~~agent~~ producer, and any material changes in its operations since the insurer's initial qualification for listing or the last annual filing under this subsection. If there have been material changes in operations, the officer shall describe the changes. In this subsection, material changes include a change in any ~~1~~ one or a combination of the following:

        i. A director, officer, or controlling person;

        ii. The insurer's holding company or affiliates;

        iii. The insurer's charter documents, including its articles of incorporation, articles of agreement, or by-laws governing its conduct of business;

iv. The insurer's marketing or administration plans, operations, or agreements with ~~3rd~~ third parties;

v. Any other matter material to the insurer meeting its obligations to its policyholders; and

vi. Any other matter that relates to any of the grounds for removal from the list as prescribed in A.R.S. § 20-413.

c. The insurer's officer shall state whether the insurer is in good standing in all jurisdictions where it conducts insurance business and whether the insurer has been, since the date of initial listing or the last annual filing under this subsection, or currently is, the subject of any action or order by any regulatory official in any jurisdiction. If the insurer has been or is the subject of a disciplinary action or order, the insurer's officer shall describe the matter in the affidavit and shall attach a copy of any applicable official document. In this subsection, regulatory action or order includes any ~~1~~ one or a combination of the following:

i. Denial, suspension, or revocation of a license, permit, or certificate of authority;

ii. A corrective action or operation plan, consent order, memorandum of understanding, or cease and desist order;

iii. Action against the insurer's bond or securities held in trust by a regulatory official; and

iv. Supervision, conservatorship, receivership, or any other form of possession or control by a regulatory official in any jurisdiction.

d. The insurer's officer shall state whether the report of examination, if any, previously filed with the Director under subsection (E)(3) or with a previous annual filing, remains the most current, filed report. If a more recent report of examination exists, the surplus lines broker shall file a copy of the report with the affidavit.

H. Supplemental information; removal. A surplus lines broker and an unauthorized insurer shall provide any additional information the Director requests to determine whether the insurer meets the requirements of A.R.S. § 20-413, or to clarify documents filed under this Section. The Director may remove an insurer from the list if the surplus lines broker or insurer does not submit the requested information within 30 days after the date of a written request for information.

I. Removal for failure to make annual filing. The Director shall remove an unauthorized insurer from the list if a surplus lines broker fails to timely file the documents required by subsection (G). The Director shall not restore the insurer to the list until a surplus lines broker files all applicable documents required under subsections (E) and (F) and the insurer requalifies under A.R.S. § 20-413.

J. Organizations of surplus lines brokers; unauthorized insurer.

1. A surplus lines broker may file records or reports that are subject to examination with any voluntary organization of surplus lines brokers. The Director may examine the records or reports filed with an organization of

surplus lines brokers to ascertain compliance with A.R.S. Title 20, Chapter 2, Article 5. An examination performed under this authority shall not preclude examination of records of a surplus lines broker.

2. Nothing in this rule requires that a surplus lines broker become a member of any surplus lines organization to file or to preserve or maintain any affidavit or statement.

~~R20-6-206.~~R20-6-205. ~~Repealed~~ Local or Regional Retaliatory Tax Information

A. Definitions.

1. "Addition to the rate of tax" means the tax rate determined under subsection ~~(E)~~ (D) to be applied under A.R.S. 20-230(A) and this Section to foreign or alien insurers domiciled in a foreign country or other state having local or regional taxes.
2. "Alien insurer" has the meaning prescribed in A.R.S. § 20-201.
3. "Arizona life insurer" means a domestic insurer authorized to issue life insurance policies in this state ~~under~~ within the meaning of A.R.S. § 20-254 or annuities ~~under~~ within the meaning of A.R.S. § 20-254.01 regardless of whether the insurer is authorized to transact disability insurance in this state
4. "Department" means the Arizona Department of Insurance.
5. "Director" has the meaning prescribed in A.R.S. § 20-102.
6. "Domestic insurer" has the meaning prescribed in A.R.S. § 20-203.

7. "Foreign insurer" has the meaning prescribed in A.R.S. § 20-204.

8. "Foreign or alien life insurer" means a foreign or alien insurer authorized to issue life insurance policies in this state within the meaning of A.R.S. § 20-254 or annuities within the meaning of A.R.S. § 20-254.01 regardless of whether the insurer is authorized to transact disability insurance in this state.

9. "Local or regional taxes" means any tax, license, or other obligation imposed upon domestic insurers or their ~~agents~~ producers by any:

   a. City, county, or other political subdivision of a foreign country or other state; or

   b. A combination of cities, counties, or other political subdivisions of a foreign country or other state.

10. "Other Arizona insurer" means a domestic insurer authorized to transact ~~1~~ one or more lines of insurance in this state but not authorized to transact life insurance or annuities in this state.

11. "Other foreign or alien insurer" means a foreign or alien insurer authorized to transact ~~1~~ one or more lines of insurance in this state but not authorized to transact life insurance or annuities in this state.

12. "Other state" means any state in the United States, the District of Columbia and territories or possessions of the United States but excluding Arizona.

13. "Premium Tax and Fees Report," including the "Survey of Arizona Domestic Insurers" and the "Retaliatory Taxes and Fees Worksheet,"

means the form prescribed by the Director and filed annually by insurers ~~pursuant to~~ under A.R.S. § 20-224.

~~C~~B. Scope. This rule applies to all foreign, alien, and domestic insurers.

~~D~~C. Data to be Reported by Domestic Insurers. Each domestic insurer shall file a Survey of Arizona Domestic Insurers as part of its Premium Tax and Fees Report. The Survey shall report the following data for the calendar year covered by the insurer's Premium Tax and Fees Report with respect to each foreign country or other state in which the insurer was required to pay any local or regional taxes:

1. Total local or regional taxes paid; and
2. Total premiums taxed under the premium taxing statute of the foreign country or other state, as reported by the insurer in any premium tax report filed under the laws of the foreign country or other state.

~~E~~D. Computation of Statewide and Foreign Countrywide Additions to the Rate of Tax. For each foreign country or other state having ~~1~~ one or more local or regional taxes on domestic insurers, the Department shall compute on a statewide or foreign countrywide basis an addition to the rate of tax. The Department shall compute the addition to the rate of tax payable by Arizona life insurers separately from the addition to the rate of tax payable by other Arizona insurers. The addition to the rate of tax payable by each category of Arizona domestic insurers shall be the quotient of:

1. The aggregate local or regional taxes reported as paid to the foreign country or other state by domestic insurers in each category for the calendar year covered by the Premium Tax and Fees Report divided by,

2. The aggregate statewide or foreign countrywide premiums taxed under the premium taxing statute of the state or foreign country reported by domestic insurers in each category for the calendar year covered by the Premium Tax and Fees Report.

~~F~~E. Publication of Additions to the Rate of Tax. The Department shall publish additions to the rate of tax determined under A.R.S. § 20-230(A) and this Section, based upon the survey information gathered from domestic insurers for the preceding calendar year ~~pursuant to~~ under subsection ~~(D)~~ (C). The Department shall publish the information annually, on or before November 1, and in the Retaliatory Taxes and Fees Worksheet for the next year's Premium Tax and Fees Report.

~~G~~F. Foreign and Alien Insurers' Report of the Effect of Local or Regional Taxes. Each foreign or alien insurer domiciled in a foreign country or other state for which the Department publishes an addition to the rate of tax shall include in the "State or Country of Incorporation" column of its Retaliatory Taxes And Fees Worksheet for the calendar year covered by its Premium Tax and Fees Report an amount equal to:

1. The total premiums received in Arizona that would be taxed under the laws of the domiciliary jurisdiction, as reported in the "State or Country of Incorporation" column of its premium tax and fees report multiplied by,
2. The applicable addition to the rate of tax published by the Department for the calendar year covered by the insurer's Premium Tax and Fees Report.

~~H~~**G.** Contest of Computation. A foreign or alien insurer subject to this rule may preserve the right to contest the computation of the addition to the rate of tax by submitting a notice of appeal under A.R.S. Title 41, Chapter 6, Article 10 before or at the time the retaliatory tax is paid. Subject to A.R.S. § 20-162, the filing of a notice of appeal to contest the computation of the applicable addition to the rate of tax does not relieve a foreign or alien insurer of the obligation to timely pay the retaliatory tax, and does not stay accrual of any applicable interest and penalties.

~~I~~**H.** Application. This rule applies to Premium Tax and Fees Reports filed by all insurers ~~for the calendar year 1998 and all subsequent years~~.

~~R20-6-207.~~R20-6-206. Industrial Insureds

~~**A.** Authority -- This rule is adopted pursuant to A.R.S. §§ 20-106, 20-143 and 20-401.01 through 20-401.07.~~

~~**B.** Purpose -- The purpose of this rule is to implement the legislative intent, as expressed in Chapter 23, Laws of 1972, to regulate and control industrial insureds contracting with unauthorized insurers in this state.~~

~~**C.** Scope -- The scope of this rule is A.R.S. Title 20 and the information and returns required by this rule are declared necessary for the protection of residents of this state.~~

~~**D.** Repeal -- This rule does not repeal any known prior rule, memorandum, bulletin, directive, or opinion on this subject matter.~~

~~E~~**A.** Definitions. ~~-- As used in~~ In this rule, unless the context otherwise requires:

1. “Admitted insurer” means an insurer that the Director has issued a certificate of authority to transact insurance in this state under A.R.S. §§ 20-216 and 20-217.

~~1~~2. "Director" means the Director of Insurance of the State of Arizona;

~~2~~3. "Gross premium" means the total premium charged, deducted or allocated including membership fees, assessments, dues and any other consideration for insurance, less premiums returned on account of cancellation or reduction of premium;

~~3~~4. "Industrial insured" has the meaning of A.R.S. § 20-401.07(B) ~~and all of the qualifying attributes of such subsection. The term~~ and includes self-insureds ~~if~~ for any risk or exposure or partial risk ~~or exposure is insured by a non-admitted insurer~~;

~~4~~5. "Insurer" has the same meaning ~~of~~ prescribed in A.R.S. § 20-106(C);

~~5. "Reciprocal state" has the meaning of A.R.S. § 20-401;~~

6. "Transact" or “transaction” has the same meaning ~~of~~ as prescribed in A.R.S. § 20-106(A) and (B) ~~and the following provisions~~ of ~~subparagraph (a)~~:

~~a. Any of the following acts in this state effected by mail or otherwise, by or on behalf of an unauthorized insurer, is deemed to constitute the transaction of an insurance business in this state:~~

~~i. The making of or proposing to make, as an insurer, an insurance contract.~~

ii. The making of or proposing to make, as guarantor or surety, any contract of guaranty or suretyship as a vocation and not merely incidental to any other legitimate business or activity of the guarantor or surety.

iii. The taking or receiving of any application for insurance.

iv. The receiving or collection of any premium, commission, membership fees, assessments, dues or other consideration for any insurance or any part thereof.

v. The issuance or delivery of contracts of insurance to residents of this state or to persons authorized to do business in this state.

vi. Directly or indirectly acting as an agent for or otherwise representing or aiding on behalf of another any person or insurer in the solicitation, negotiation, procurement or effectuation of insurance or renewals thereof or in the dissemination of information as to coverage or rates, or forwarding of applications, or delivery of policies or contracts, or inspection of risks, a fixing of rates or investigation or adjustment of claims or losses or in the transaction of matters subsequent to effectuation of the contract and arising out of it, or in any other manner representing or assisting a person or insurer in the transaction of insurance with respect to subjects of

~~insurance resident, located or to be performed in this state. The provisions of this subsection shall not operate to prohibit full-time salaried employees of a corporate insured from acting in the capacity of an insurance manager or buyer in placing insurance in behalf of such employer.~~

~~vii. The transaction of any kind of insurance business specifically recognized as transacting an insurance business within the meaning of the statutes relating to insurance.~~

~~viii. The transacting or proposing to transact any insurance business in substance equivalent to any provisions as provided in subdivisions (i) to (viii), inclusive, of this Section in a manner designed to evade the laws of this state.~~

7. "Unauthorized insurer" ~~as used herein~~ means an insurer transacting business in this state who ~~has not qualified for a certificate of authority, approval to operate as a non-admitted insurer, or for~~ is not an admitted insurer, is not a listed qualified unauthorized insurer under R20-6-204(C), and has not been issued a certificate of exemption ~~and filed a tax return and paid the premium taxes made a condition of such qualification pursuant to R20-6-404~~ under A.R.S. § 20-401.05.

~~F~~B. ~~Applicability of the rule~~

~~1.~~ A.R.S. § 20-401.07 and this ~~rule~~ Section apply to all insurance transacted by an unauthorized insurer with an industrial insured~~,~~ for which premiums,

in whole or in part, are remitted directly or indirectly from within or outside this state and whether procured ~~through negotiation~~ by direct application, by mail, by an insurance producer on the industrial insured's behalf, or by ~~an application, in whole or in part, occurring or made within or outside this state~~ any other means.

~~2. A.R.S. § 20-401.07 and this rule apply to all insurance transacted by an unauthorized insurer with an industrial insured for which premiums, in whole or in part, are remitted directly or indirectly from within or outside this state.~~

~~G~~C. ~~Return and premium required~~ Tax to be paid by industrial insureds contracting with an unauthorized insurer.~~—~~ Every industrial insured under a contract procured from an unauthorized insurer shall pay to the Director, before ~~April~~ March 1st ~~next following~~ after the calendar year in which the insurance was effectuated, continued, or renewed, a premium receipt tax of 3% of the gross premiums charged, deducted or allocated~~,~~ to persons, residents or property located in, or contracts to be performed in this state and by A.R.S. § 20-401.07 deemed to be insurance effectuated or continued in this state. The return for premium receipts tax shall be prepared, executed and filed on ~~Form E-166 attached hereto and made part hereof~~ a form prescribed by the Director.

~~H~~D. ~~Risks partly in this state~~

~~1.~~ If an industrial insured claims that the insurance contract with an unauthorized insurer covers risks or exposures only partly in this state, the industrial insured shall file~~, in addition to and accompanying~~ with the

Department the premium receipts tax return, and a certified statement ~~clearly disclosing information necessary for a determination of the criteria of percentage allocation of A.R.S. § 20-401.07, including but not limited to~~ containing the following information on a form prescribed by the Director :

~~a.~~1. Percentage of physical assets in Arizona~~.~~,

~~b.~~2. Percentage of employee payroll in Arizona~~.~~,

~~c.~~3. Percentage of sales in Arizona~~.~~, and

~~d.~~4. Percentage of taxable income reportable in Arizona.

~~2. In addition to the statements required by (H)(1) hereof, each industrial insured shall file with the Director the computations by which the tax payable has been computed on the portions of the premium which are properly allocable to the risk or exposure located in this state.~~

~~I~~**E.** ~~Exemptions -- Persons~~ A person contracting with an unauthorized ~~insurers~~ insurer claiming ~~to be included~~ inclusion in ~~or exempt from~~ the definition of "industrial insured" ~~of~~ in A.R.S. § 20-401.07(B) shall file a certified statement ~~clearly disclosing~~ that discloses the following information for that person:

1. The ~~risk or risks insured other than life, disability and annuity contracts~~ insurance risks that are subject to the requirements of A.R.S. Title 20, Chapter 2, Article 4.1 and the identity of the insurer~~,~~;

2. ~~the identity, title and functions~~ The name of the ~~full time~~ full-time employee ~~acting as an insurance manager or buyer, or the identity, address and functions of a regularly and continuously retained qualified insurance~~

~~consultant, and~~ or third-party consultant retained to act as risk manager and the third-party consultant's qualifications under A.R.S. § 20-401.07(B)(2);

~~2~~3. The total aggregate annual gross premiums ~~of the insured and the total number of full-time employees of the insured.~~ paid for insurance on all property and casualty risks that are subject to A.R.S. Title 20, Chapter 2, Article 4.1 as of the preceding fiscal year end;

4. Net worth as of the preceding fiscal year end, as verified by a certified public accountant; and

5. The total number of full-time employees or equivalent and if less than 80, the total number of full-time or equivalent employees of its holding company system, as of the date the policy was issued by the unauthorized insurer.

~~J~~F. ~~Additional information -- In addition to the certified statements required by this rule, the~~ The Director may ~~and if requested the industrial insured or insured, shall furnish~~ require that the industrial insured provide the following additional information to the Director ~~additional information, including, but not limited to~~:

1. The mode of premium payment showing the percentage paid by employer and employee;

2. The amount of annual premium applied to life, disability, and annuity policies if additional risks are insured;

3. A statement of loss claim ratio for the preceding year by policy type~~,~~ ; and

4. The amount of reserve for policies and contracts by type of policy.

K. Failure to pay claims -- Applications for classification as, or exemption from, the definition of the industrial insureds may be denied or rejected if the applicant has failed to pay any claims or loss within the provisions of an insurance contract issued by such applicant or by an unauthorized insurer for the applicant, or deemed to be insurance effectuated or continued in this state. The provisions of this Section may be waived by the Director upon a clear affirmative showing that the applicant is defending an action in law or equity in a court of this state.

L. Reciprocal state -- The list of the states and territories qualified as reciprocal states, and maintained by the Director pursuant to the authority and instruction of A.R.S. § 20-401.04 is by reference made part of this rule.

M. Effective date

1. This rule shall become effective April 1st, 1973. All reports and returns to be filed or filed on or after the effective date of this rule, except as herein provided, shall conform to the provisions of this rule as of the effective date, April 1st, 1973. Because of the fact that compliance with the provisions of A.R.S. § 20-401.07 and this rule involve complex matters that are not fully resolvable by the effective date, the time for filing initial returns and statements is hereby extended until July 1st, 1973, provided that the premium tax due accompanies the filing of such return or statement.
2. Any industrial insured wishing to comply with A.R.S. § 20-401.07 and this rule prior to such extended date may do so by filing with the Director the required return, statement and premium tax due.

N. Other approved dates -- For good cause shown the Director may authorize industrial insured to make, complete and file returns, statements and reports required by statute or this rule on dates other than those required, if applied for in writing not less than 10 days prior to the due date of such return, statement, report or accounting.

O. Severability -- If any provision of this rule or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect the provisions or applications of the rule which can be given effect without the invalid provision or application, and to this end the provisions of this rule are declared to be severable.

P. Forms -- The filing of returns, reports, statements or accountings prescribed by this rule are not subject of a precise or specific form other than Forms A-1 and A-2 hereof. Filings shall adequately disclose the information required by statutes and this rule. If additional specific forms are hereafter adopted by the Department, such specific forms shall be prepared, executed and filed in accordance with such forms and the instructions attached thereto

Q. Adoption -- Notice of proposed adoption of this rule, together with a true copy thereof was filed in the Office of the Secretary of State on the 26th day of March, 1973, and a hearing thereof, pursuant to such notice, was held on the 24th day of April, 1973, when, pursuant to arguments made at such hearing and written memorandum filed thereafter, this rule was adopted on the 24th day of April, 1973. This rule shall become effective on the 1st day of April, 1973, pursuant to subsection (M) hereof.

~~R20-6-209.~~R20-6-207. ~~Unfair Sex~~ Gender Discrimination

~~A. Authority. This rule is adopted pursuant to A.R.S. §§ 20-142, 20-143, and 20-448.~~

~~B. Purpose. The purpose of this rule is to eliminate the act of denying benefits or coverage on the basis of sex or marital status in the terms and conditions of insurance contracts and in the underwriting criteria of insurance carriers and to implement A.R.S. § 20-448, Unfair Discrimination.~~

~~C.~~**A.** Definitions:

1. “Applicant” means a person who is applying for a policy.

~~1.~~ 2. ~~"Contracts" mean~~ “Policy” means ~~any~~ an insurance policy, plan, contract, certificate, evidence of coverage, subscription contract, or binder, including ~~any~~ a rider or endorsement ~~thereto~~ offered by an insurer.

~~2.~~ 3. "Insurer" ~~has the meaning of A.R.S. §§ 20-104 and 20-106(c)~~ means any company that issues a policy.

~~D.~~**B.** Applicability and scope. This rule ~~shall apply~~ applies to ~~all contracts~~ any policy or certificate delivered or issued for delivery in this state ~~by an insurer on or after the effective date of this rule and to all existing group contracts which are amended on or after the effective date of this rule~~.

~~E.~~**C.** Availability requirements~~.~~

1. ~~Availability~~ An insurer shall not deny availability of any insurance ~~contract shall not be denied to an insured or prospective insured~~ policy on the basis of the ~~sex~~ gender or marital status of the insured or prospective insured.

2. ~~The~~ An insurer shall not restrict, modify, exclude, reduce, or limit the amount of benefits payable, or any term, conditions or type of coverage ~~shall not be restricted, modified, excluded, or reduced~~ on the basis of an applicant or insured's ~~sex~~ gender or marital status ~~of the insured or prospective insured~~, except to the extent the amount of benefits, term, conditions, or type of coverage vary as a result of the application of rate differentials permitted under A.R.S., Title 20~~, Arizona Revised Statutes~~.

3. ~~Nothing in this rule shall prohibit an~~ An insurer ~~from taking~~ may consider marital status ~~into account for the purpose of defining~~ to determine whether a ~~persons~~ person is eligible for ~~dependents~~ dependent coverage or benefits.

~~F.~~D. ~~Illustrations~~ Prohibited practices. ~~Illustrations of practices~~ The practices listed in this subsection, and other similar insurer conduct, is prohibited. ~~by this rule include, but are not limited to, the following:~~

1. Denying coverage to ~~persons~~ a person of one ~~sex gainfully employed at home~~ gender who is self-employed, employed part-time, or employed by relatives, ~~when~~ if coverage is offered to ~~persons~~ a person of the opposite ~~sex~~ gender who is similarly employed.

2. Denying a policy ~~riders~~ rider to ~~persons of one sex when~~ a person of one gender if the ~~riders are~~ rider is available to ~~persons~~ a person of the opposite ~~sex~~ gender.

3. Denying maternity benefits to ~~insureds or prospective insureds purchasing~~ an applicant or insured who buys a policy for ~~an~~ individual ~~contract~~

coverage if the insurer offers ~~when~~ comparable family coverage ~~contracts offer~~ policies with maternity benefits.

4. Denying, under group ~~contracts~~ policies, dependent coverage to ~~a spouse of~~ an employee of one ~~sex~~ gender ~~when~~ if dependent coverage is available to an employee of the opposite ~~sex~~ gender.

5. Denying a disability income ~~contracts~~ policy to an employed ~~persons~~ person of one ~~sex~~ gender ~~when~~ if ~~coverage~~ a policy is offered to ~~persons~~ a person of the opposite ~~sex~~ gender who is similarly employed.

6. Treating complications of pregnancy differently from any other illness or sickness covered under ~~the contracts~~ a policy.

7. Restricting, reducing, modifying, or excluding benefits relating to coverage involving the genital organs of only one ~~sex~~ gender.

8. Offering lower maximum monthly benefits to ~~persons~~ a person of one ~~sex~~ gender than to ~~persons~~ a person of the opposite ~~sex~~ gender who ~~are~~ is in the same classification under a disability income ~~contract~~ policy.

9. Offering more restrictive benefit periods ~~and~~ or more restrictive definitions of disability to ~~persons of one sex~~ a person of one gender than to ~~persons~~ a person of the opposite ~~sex~~ gender who is in the same ~~classifications~~ classification under a disability income ~~contract~~ policy.

10. Establishing different conditions ~~by sex under which the~~ for a policyholder of one gender to ~~may~~ exercise benefit options contained in the ~~contract~~ policy than for a person of the opposite gender.

11. Limiting the amount of coverage an insured or prospective insured may purchase based upon the insured's or prospective insured's marital status unless such limitation is for the purpose of defining persons eligible for dependent's benefits.

12. Otherwise restricting, modifying, excluding or reducing the availability of any insurance contracts, the amount of benefits payable, or any term, condition or type of coverage on account of ~~sex~~ gender or marital status in all lines of insurance.

~~G. Severability. If any provision of this rule or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect the provisions or applications of the rule which can be given effect without the invalid provision or application, and to this end the provisions of this rule are declared to be severable.~~

~~H. Effective date. This rule shall become effective immediately upon a certified copy of the same being filed in the office of the Secretary of State of the State of Arizona but not before April 1, 1977.~~

~~R20-6-210.~~R20-6-208. ~~Expired~~ Group Coverage Discontinuance and Replacement

A. ~~Authority. This rule is adopted pursuant to A.R.S. §§ 20-142, 20-143, 20-441 through 20-460, and 20-1110.~~ Definitions. The following definitions apply in this Section:

1. "Group insurance" means an insurance benefit that meets the following conditions:

a. Coverage is provided through insurance policies or subscriber contracts to classes of employees or members defined in terms of conditions pertaining to employment or membership.

b. The coverage is not available to the general public and can be obtained and maintained only because of the covered person's membership in or connection with the particular organization or group.

c. Coverage is paid for by bulk payment of premiums to the insurer.

d. An employer, union, or association sponsors the plan.

2. "Health insurance coverage" means a hospital and medical expense incurred policy, a nonprofit health care service plan contract, a health maintenance organization subscriber contract, or any other health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise, but does not include the following:

a. Coverage only for accident, or disability income insurance, or any combination of accident or disability income insurance;

b. Coverage issued as a supplement to liability insurance;

c. Liability insurance, including general liability insurance and automobile liability insurance;

d. Workers' compensation or similar insurance;

e. Automobile medical payment insurance;

f. Credit-only insurance;

g. Coverage for on-site medical clinics; and

h. Other similar insurance coverage, specified in federal regulations issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Pub.L.No. 104-191), under which benefits for medical care are secondary or incidental to other insurance benefits.

i. The following benefits, if the benefits are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the coverage:

i. Limited-scope dental or vision benefits;

ii. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination of the benefits;

iii. Other similar, limited benefits specified in federal regulations issued under HIPAA.

j. The following benefits if provided under a separate policy, certificate, or contract of insurance with no coordination between provision of benefits and any exclusion of benefits under a group health plan maintained by the same plan sponsor and if the benefits are paid for an event regardless of whether the benefits are provided under a group health plan maintained by the same plan sponsor:

i. Coverage only for a specified disease or illness; or

ii. Hospital indemnity or other fixed indemnity insurance.

k. The following benefits if the benefits are offered as a separate policy, certificate, or contract of insurance:

i. Medicare supplemental health insurance as defined under § 1882(g)(1) of the Social Security Act;

ii. Coverage supplemental to the coverage provided under, Title 10, Chapter 55, United States Code; or

iii. Similar supplemental coverage provided to coverage under a group health plan.

2. "Health status-related factor" means any of the following:

a. Health status;

b. Medical condition, including a physical or mental illness;

c. Claims experience;

d. Receipt of health care;

e. Medical history;

f. Genetic information;

g. Evidence of insurability, including conditions arising out of acts of domestic violence; or

h. Disability.

3. "Insurer" means an insurer that offers or provides group health insurance coverage, and includes an insurer that issues disability insurance as defined in A.R.S. § 20-253, a medical, dental, optometric service

corporation as defined in A.R.S. § 20-822, and a health care services organization as defined in A.R.S. § 20-1051.

B. ~~Scope.~~This ~~rule~~ Section ~~is applicable~~ applies to all group insurance ~~policies and subscriber contracts~~ issued ~~or provided~~ by an ~~insurance company or a non-profit service corporation on a group or group-type basis covering persons as employees of employers or as members of unions (or associations)~~ insurer.

~~**C.** Definition. The term "group-type basis" means a benefit plan, other than "salary budget" plans utilizing individual insurance policies or subscriber contracts, which meets the following conditions:~~

~~1. Coverage is provided through insurance policies or subscriber contracts to classes of employees or members defined in terms of conditions pertaining to employment or membership.~~

~~2. The coverage is not available to the general public and can be obtained and maintained only because of the covered person's membership in or connection with the particular organization or group.~~

~~3. There are arrangements for bulk payment of premiums or subscription charges to the insurer or non-profit service corporation.~~

~~4. There is sponsorship of the plan by the employer, union (or association).~~

~~**D**~~**C.** Effective date of discontinuance for non-payment of premium ~~or subscription charges~~

1. If a group insurance policy ~~or contract subject to these rules and regulations~~ provides for automatic discontinuance of the policy ~~or contract~~ after a premium ~~or subscription charge has remained~~ remains unpaid

through the grace period allowed for ~~such~~ payment, the ~~carrier shall be~~ insurer is liable for valid claims for covered losses incurred ~~prior to~~ before the end of the grace period.

2. If the insurer's actions ~~of the carrier~~ after the end of the grace period indicate that ~~it~~ the insurer considers the group insurance policy ~~or contract~~ as continuing in force beyond the end of the grace period ~~(such as, by continuing to recognize claims subsequently incurred),~~ the ~~carrier shall be~~ insurer is liable for valid claims for losses beginning ~~prior to~~ before the effective date of written notice of discontinuance to the policyholder or other entity responsible for ~~making payments or submitting subscription charges to the carrier~~ paying premiums. ~~The effective date of discontinuance shall not be prior to midnight at the end of third scheduled work day after the date upon which the notice is delivered.~~

3. For the purpose of subsection (C)(2), the following actions indicate that the insurer considers the policy in force:

   a. Continued recognition, acknowledgement, or payment of subsequently incurred claims; or

   b. Continued enrollment of employees or dependents.

4. For purposes of subsection (C)(2), the following actions shall not indicate that the insurer considers that policy in force:

   a. Recognition, payment, or acknowledgement of a claim by an insurer for processing a denial based on eligibility or other denial reasons set forth in the group benefit plan booklet; or

b. Recognition, payment, or acknowledgement of claims due to the group's failure to notify the insurer that the employee is no longer eligible for coverage or the group policy is terminated.

5 The effective date of discontinuance shall not be before midnight at the end of the third scheduled work day after the date on which the notice is delivered.

~~E~~ **D.** Requirements for notice of discontinuance

1. ~~Any~~ An insurer's notice of discontinuance ~~so given by the carrier~~ shall include a request to the group policyholder ~~or other entity involved~~ to notify covered employees ~~covered under the policy or subscriber contract~~ of the date ~~as of which~~ when the group policy or contract will discontinue and to advise that, unless otherwise provided in the policy or contract, the ~~carrier shall~~ insurer is not be liable for claims for losses incurred after ~~such~~ the date of discontinuance. ~~Such~~ If the plan involves employee contributions, the notice of discontinuance shall also advise~~, in any instance in which the plan involves employee contributions,~~ that if the policyholder ~~or in any instance in which the plan involves employee contributions, that if the policyholder or other entity~~ continues to collect employee contributions ~~for the coverage~~ beyond the date of discontinuance, the policyholder ~~or other entity may be held~~ is solely liable for the benefits ~~with respect to~~ for which ~~the~~ contributions ~~have been~~ were collected.

2. The ~~carrier will~~ insurer shall also ~~prepare and furnish to~~ provide the policyholder ~~or other entity at the same time~~ with a supply of ~~a~~ notice ~~form to be distributed~~ forms that the policyholder can distribute to the covered employees. ~~or members concerned indicating such~~ The notice forms shall explain the discontinuance and the effective date ~~thereof~~, and ~~urging~~ advise ~~the~~ employees ~~or members~~ to refer to their certificates or contracts ~~in order~~ to determine ~~what~~ their rights~~, if any, are available to them upon such~~ on discontinuance.

~~F~~E. Extension of benefits.

1. ~~Every~~ A group policy ~~or other contract subject to these rules and regulations hereafter issued, or under which the level of benefits is hereafter altered, modified, or amended, must~~ shall provide a reasonable provision for extension of benefits ~~in the event of~~ for an employee or dependent who is ~~total disability at~~ totally disabled on the date of discontinuance ~~of the group policy or contract,~~ as ~~required by the following paragraphs of this subsection.~~ follows:

~~2~~a. ~~In the case of~~ For a group life plan ~~which contains~~ with a disability benefit extension of any type (e.g., premium waiver extension, extended death benefit in event of total disability, or payment of income for a specified period during total disability), the discontinuance of the group policy shall not ~~operate to~~ terminate ~~such~~ the benefit extension.

~~3~~b. ~~In the case of~~ For a group plan providing benefits for loss of time from work or specific indemnity during hospital confinement, discontinuance of the policy during a disability or hospital confinement shall ~~have no~~ not effect ~~on~~ benefits payable for that disability or hospital confinement.

~~4~~c. ~~In the case of~~ A hospital or medical expense ~~coverages~~ coverage, other than dental and maternity expense, shall include a reasonable extension of benefits or accrued liability provision ~~is required~~. ~~Such a~~ A provision ~~will be considered~~ is "reasonable" if:

i. ~~it~~ It provides an extension of at least 12 months under "major medical" and "comprehensive medical" type ~~coverages,~~ coverage; ~~and~~ or

ii. ~~under~~ Under other types of hospital or medical expense ~~coverages~~ coverage, provides either an extension of at least 90 days or an accrued liability for expenses incurred during a period of disability or during a period of at least 90 days starting with a specific event which occurred while coverage was in force (e.g., an accident).

~~5~~2. ~~Any applicable extension of benefits or accrued liability shall be described in any~~ The policy ~~or contract involved as well as in~~ and group insurance certificates shall include a description of the extension of benefits or accrued liability provision.

3. The benefits payable during any period of extension or accrued liability may be subject to the policy's ~~or contract's~~ regular benefit limits (e.g., benefits ceasing at exhaustion of a benefit period or of maximum benefits).

4. For hospital or medical expense coverage, the benefit payments may be limited to payments applicable to the disabling condition only.

~~G~~F. Continuance of coverage in situations involving replacement of one ~~carrier~~ plan by another.

1. ~~This Section shall indicate the carrier responsible for liability in those instances in which one carrier's contract~~ When a group policyholder secures replacement coverage with a new insurer, self-insures, or foregoes provision of coverage, ~~replaces a plan of similar benefits of another.~~:

~~2. Liability of prior carrier. The prior carrier remains~~ the replaced insurer is liable only to the extent of its accrued liabilities and extensions of benefits after the date of discontinuance. ~~The position of the prior carrier shall be the same whether the group policyholder or other entity secures replacement coverage from a new carrier, self-insures, or foregoes the provision of coverage.~~

~~3.~~2. ~~Liability of~~ The succeeding ~~carrier.~~ insurer shall cover each individual who:

a. ~~Each person who~~ Was validly covered under the prior plan on the date of discontinuance, and

b. ~~is~~ Is eligible for coverage ~~in accordance with~~ according to the succeeding ~~carrier's~~ insurer's plan of benefits ~~(in respect of~~ with respect to the class or classes of individuals eligible for coverage and ~~activity~~ any actively-at-work and non-confinement rules~~) shall be covered by that plan of benefits~~.

3. For the purpose of successive health insurance coverage under subsection (F)(2), a succeeding insurer's plan of benefits shall:

a. Not have any nonconfinement rules; and

b. Provide, as to any actively-at-work rules, that absence from work due to a health-status related factor is treated as being actively-at-work.

4. Nothing in subsection (F)(2) prohibits an insurer from performing coordination of benefits.

~~b.~~ 5. A succeeding insurer shall cover each individual ~~Each person~~ not covered under the succeeding ~~carrier's~~ insurer's plan of benefits ~~in accordance with subparagraph (a) above must nevertheless~~ under subsection (F)(2) ~~be covered by the succeeding carrier in accordance with~~ according to the following rules if ~~such~~ the individual was validly covered, ~~(~~including benefit extension~~)~~, under the prior plan on the date of discontinuance and ~~if such individual~~ is a member of the class or classes of individuals eligible for coverage under the succeeding ~~carrier's~~ insurer's plan. Any reference in the following rules to an individual who was or was not totally disabled is a reference to the individual's status immediately ~~prior~~

~~to~~ before the effective date of coverage for the succeeding ~~carrier's coverage becomes effective~~ insurer.

~~i.~~a. The minimum level of benefits to be provided by the succeeding ~~carrier~~ insurer shall be the applicable level of benefits of the prior carrier's insurer's plan reduced by any benefits payable by the prior plan.

~~ii.~~b. The succeeding insurer shall provide coverage ~~Coverage must be provided by the succeeding carrier~~ until at least the earliest of the following dates:

~~(1)~~i. The date the individual becomes eligible under the succeeding ~~carrier's~~ insurer's plan as described in ~~subparagraph (a) above~~ subsection (F)(2).

~~(2)~~ii. ~~For each type of coverage, the~~ The date the individual's coverage would terminate ~~in accordance with~~ according to the succeeding ~~carrier's~~ insurer's plan provisions applicable to individual termination of coverage (e.g., at termination of employment or ceasing to be eligible dependent~~, as the case may be~~).

~~(3)~~ iii. ~~In the case of~~ For an individual who was totally disabled, and in the case of a type of coverage for which subsection ~~(F)~~ (E) requires an extension of accrued liability, the end of any period of extension of benefits or accrued liability which is required of the prior ~~carrier by~~ insurer under

subsection ~~(F)~~ (E), or, if the prior ~~carrier's~~ insurer's policy ~~or contract~~ is not subject to that subsection, would have been required of that ~~carrier~~ insurer had its policy or contract been subject to subsection ~~(F)~~ (E) at the time the prior plan was discontinued and replaced by the succeeding ~~carrier's~~ insurer's plan.

iv. For health insurance coverage, in the case of an individual who was totally disabled at the time the prior insurer's plan was discontinued and replaced by the succeeding insurer's plan, and in the case in which subsection (E) requires an extension of benefits or accrued liability, the minimum level of benefits to be provided by the succeeding insurer shall be the applicable level of benefits of the prior insurer's plan, reduced by any benefits paid by the prior plan.

c. ~~In the case of a preexisting conditions limitation included in~~ If the succeeding ~~carrier's~~ insurer's plan has a preexisting conditions limitation, the level of benefits applicable to preexisting conditions of persons becoming covered by the succeeding ~~carrier's~~ insurer's plan ~~in accordance with~~ according to ~~this~~ subsection ~~(G)~~ (F) during the period of time this limitation applies under the new plan shall be the lessor of:

i. The benefits of the new plan determined without application of the preexisting conditions limitation~~;~~ , and

ii. The benefits of the prior plan.

d. The succeeding ~~carrier~~ insurer, in applying any deductibles, coinsurance amounts applicable to the out-of-pocket maximums, or waiting periods in its plan, shall give credit for the satisfaction or partial satisfaction of the same or similar provisions under a prior plan providing similar benefits. ~~In the case of~~ For deductible provisions or coinsurance amounts applicable to the out-of-pocket maximums, the credit shall apply for the same or overlapping benefit periods and shall be given for expenses actually incurred and applied against the deductible or coinsurance provisions of the prior ~~carrier's~~ plan during the 90 days preceding the effective date of the succeeding ~~carrier's~~ insurer's plan but only to the extent these expenses are recognized under the terms of the succeeding ~~carrier's~~ insurer's plan and are subject to similar deductible or coinsurance ~~provision~~ provisions.

e. ~~In any situation where~~ If the succeeding insurer is required to make a determination ~~of~~ about the benefits in the prior ~~carrier's benefit is required by the succeeding carrier, at~~ plan, the succeeding ~~carrier's~~ insurer may ~~request~~ ask the prior ~~carrier shall furnish~~ plan to provide a statement of the benefits available or pertinent information, sufficient to permit the succeeding insurer to

~~verification of~~ verify the benefit determination ~~or the determination itself by the succeeding carrier~~. For the purposes of this Section, ~~benefits of the prior plan will be determined in accordance with~~ all ~~of the~~ definitions, conditions, and covered expense provisions of the prior plan shall govern the benefit determination ~~rather than those of the succeeding plan~~. The benefit determination ~~will be~~ is made as if the succeeding insurer had not replaced coverage ~~had not been replaced by the succeeding carrier~~.

~~H. Effective date. This rule shall become effective 120 days after a certified copy of this rule is filed in the office of the Secretary of State of the State of Arizona.~~

~~R20-6-211.~~R20-6-209. Life Insurance Solicitation

~~A. Authority. This rule is adopted and promulgated by the Director of Insurance pursuant to A.R.S. §§ 20-142, 20-143, 20-441 through 20-460, 20-1110 and 20-1111.~~

~~B. Purpose~~

~~1. The purpose of this rule is to require insurers to deliver to purchasers of life insurance information which will improve the buyer's ability to select the most appropriate plan of life insurance for his needs, improve the buyer's understanding of the basic features of the policy which has been purchased or which is under consideration and improve the ability of the buyer to evaluate the relative costs of the similar plans of life insurance.~~

~~2. This rule does not prohibit the use of additional material which is not in violation of this rule or any other state statute or rule.~~

~~C~~**A.** Scope.

1. ~~Except as hereinafter exempted, this rule shall apply~~ This Section applies to any solicitation, negotiation, or procurement of life insurance occurring ~~within this state~~ in Arizona. This ~~rule shall apply~~ Section applies to any issuer of life insurance contracts including fraternal benefit societies.
2. Unless otherwise specifically included, the rule ~~shall~~ does not apply to:
    a. Annuities~~.~~,
    b. Credit life insurance~~.~~,
    c. Group life insurance~~.~~,
    d. Life insurance policies issued in connection with pension and welfare plans as defined by and ~~which~~ that are subject to the Federal Employee Retirement Income Security Act of 1974 (ERISA)~~.~~; or
    e. Variable life insurance under which the death benefits and cash values vary ~~in accordance with~~ unit values of investments held in a separate account.

~~D.~~**B.** ~~Definitions. For the purpose of this rule~~ In this Section, the following definitions ~~shall~~ apply:

1. "Buyer's Guide~~.~~" ~~A Buyer's Guide is~~ means a document ~~which~~ that contains~~, and is limited to,~~ the language ~~contained~~ in the Appendix to this ~~rule~~ Section or language approved by the Director ~~of Insurance~~.
2. "Cash dividend~~.~~" ~~A cash dividend is~~ means the current illustrated dividend ~~which~~ that can be applied toward payment of the gross premium.

3. "Equivalent Level Annual Dividend~~.~~" ~~The Equivalent Level Annual Dividend is~~ means the dividend that is calculated ~~by applying the following steps~~ as follows:

   a. Accumulate the annual cash dividends at 5% interest compounded annually to the end of the ~~tenth~~ 10th and ~~twentieth~~ 20th policy years~~.~~;

   b. Divide each accumulation ~~of Step~~ in subsection (a) by an interest factor that converts it onto one equivalent level annual amount that, if paid at the beginning of each year, would accrue to the values in ~~Step~~ subsection (a) over the respective periods stipulated in ~~Step~~ subsection (a). If the period is 10 years, the factor is 13.207 and if the period is 20 years, the factor is 34.719.

   c. Divide the results ~~of Step~~ in subsection (b) by the number of thousands of the Equivalent Level Death Benefit to arrive at the "Equivalent Level Annual Dividend."

4. "Equivalent Level Death Benefit~~.~~" ~~The Equivalent Level Death Benefit~~ means the amount of benefit of a policy or term life insurance rider ~~is an amount~~ calculated as follows:

   a. Accumulate the guaranteed amount payable upon death, regardless of the cause of death, at the beginning of each policy year for 10 and 20 years at 5% interest compounded annually to the end of the ~~tenth and twentieth~~ 10^{th} and 20th policy years respectively.

   b. Divide each accumulation ~~of Step~~ in subsection (a) by an interest factor that converts it into one equivalent level annual amount that, if paid at the beginning of each year, would accrue to the value in ~~Step~~ subsection (a) over

the respective periods stipulated in ~~Step~~ subsection (a). If the period is 10 years, the factor is 13.207 and if the period is 20 years, the factor is 34.719.

5. "Generic Name~~.~~" ~~Generic Name~~ means a short title ~~which is~~ descriptive of the premium and benefit patterns of a policy or a rider.

6. ~~"Life Insurance Cost Indexes."~~

~~a.~~ "Life Insurance Surrender Cost Index." ~~The Life Insurance Surrender Cost Index~~ means the cost index that is calculated ~~by applying the following steps~~ as follows:

~~i~~a. Determine the guaranteed cash surrender value, if any, available at the end of the ~~tenth and twentieth~~ 10^{th} and 20th policy years.

~~ii~~b. For participating policies, add the terminal dividend payable upon surrender, if any, to the accumulation of the annual Cash Dividends at 5% interest compounded annually to the end of the period selected and add this sum to the amount determined in ~~Step~~ subsection ~~(i)~~(a).

~~iii~~c. Divide the result ~~of Step ii.~~ in subsection ~~(ii)~~(b) (~~Step~~ subsection ~~(i)~~(a) for guaranteed-cost policies) by an interest factor that converts into an equivalent level annual amount that, if paid at the beginning of each year, would accrue to the value in ~~Step ii~~ subsection ~~(ii)~~(b). (~~Step~~ subsection ~~(i)~~(a) for guaranteed cost policies) over the respective periods stipulated in ~~Step~~ subsection ~~(i)~~(a)). If the period is 10 years, the factor is 13.207 and if the period is 20 years, the factor is 34.719.

~~iv~~d. Determine the equivalent level premium by accumulating each annual premium payable for the basic policy or rider at 5% interest

compounded annually to the end of the period stipulated in ~~Step~~ subsection ~~(i)~~(a) and dividing the result by the respective factors stated in ~~Step~~ subsection ~~(iii)~~(c) (this amount is the annual premium payable for a level premium plan).

~~v~~e. Subtract the result of ~~Step~~ subsection ~~(iii)~~(c) from ~~Step~~ subsection ~~(iv)~~(d).

~~vi~~f. Divide the result of ~~Step~~ subsection ~~(v)~~(e) by the number of thousands of the Equivalent Level Death Benefit to arrive at the Live Insurance Surrender Cost Index.

~~b~~7. "~~Life Insurance Net Payment Cost Index.~~" The Life Insurance Net Payment Cost Index is calculated in the same manner as the comparable Life Insurance Cost Index except that the cash surrender value and any terminal dividend are set at zero.

~~7~~8. "Policy Summary~~.~~" ~~For the purposes of this rule, Policy Summary~~ means a written statement describing elements of the policy including ~~but not limited to~~:

a. A prominently placed title as follows: Statement of Policy Cost and Benefit Information.

b. The name and address of the insurance ~~agent~~ producer, or, if no ~~agent~~ producer is involved, a statement of the procedure to be followed in order to receive responses to inquiries regarding the Policy Summary.

c. The full name and home office or administrative office address of the company in which the life insurance policy is to be or has been written.

d. The generic name of the basic policy and each rider.

e. ~~The following amounts, where applicable, for~~ For the first five policy years and representative policy years thereafter sufficient to clearly illustrate the premium and benefit patterns, including~~, but not necessarily limited to,~~ the years for which Life Insurance Cost Indexes are displayed and at least one age from 60 through 65 or maturity ,whichever is earlier~~.~~, the following amounts where applicable:

i. The annual premium for the basic policy~~.~~;

ii. The annual premium for each optional rider~~.~~;

iii. Guaranteed amount payable upon death, at the beginning of the policy year regardless of the cause of death other than suicide, or other specifically enumerated exclusions~~, which is~~ provided by the basic policy and each optional rider, with benefits provided under the basic policy and each rider shown separately~~.~~;

iv. Total guaranteed cash surrender values at the end of the year with values shown separately for the basic policy and each rider~~.~~;

v. Cash dividends payable at the end of the year with values shown separately for the basic policy and each rider. ~~(~~Dividends need not be displayed beyond the twentieth policy year~~.~~;~~)~~ and

vi. Guaranteed endowment amounts payable under the policy ~~which~~ that are not included under guaranteed cash surrender values ~~above~~ in subsection (iv).

f. The effective policy loan annual percentage interest rate, if the policy contains this provision, specifying whether this rate is applied in advance

or in arrears. If the policy loan interest rate is variable, the Policy Summary ~~includes~~ shall include the maximum annual percentage rate.

g. Life Insurance Cost Indexes for 10 and 20 years but in no case beyond the premium-paying period. Separate indexes ~~are~~ shall be displayed for the basic policy and for each optional term life insurance rider. ~~Such~~ The indexes need not be included for optional riders ~~which~~ that are limited to benefits such as accidental death benefits, disability waiver of premium, preliminary term life insurance coverage of less than 12 months, and guaranteed insurability benefits, nor for basic policies or optional riders covering more than one life.

h. The Equivalent Level Annual Dividend in the case of participating policies and participating optional term life insurance riders, under the same circumstances and for the same durations at which Life Insurance Cost Indexes are displayed.

i. ~~A~~ If the Policy Summary ~~which~~ includes dividends, ~~shall also include~~ a statement that dividends are based on the ~~company's~~ insurer's current dividend scale and are not guaranteed in addition to a statement in close proximity to the Equivalent Level Annual Dividend as follows: "An explanation of the intended use of the Equivalent Level Annual Dividend is included in the Life Insurance Buyer's Guide."

j. A statement in close proximity to the Life Insurance Cost Indexes as follows: "An explanation of the intended use of these indexes is provided in the Life Insurance Buyer's Guide."

k. The date on which the Policy Summary is prepared. The Policy Summary ~~must~~ shall consist of a separate document. All information required to be disclosed ~~must~~ shall ~~be set out in such a manner as to not minimize or render any portion thereof~~ not be minimized or obscure. Any amounts ~~which~~ that remain level for two or more years of the policy may be represented by a single number ~~if it is clearly indicated~~ that clearly indicates what amounts are applicable for each policy year. Amounts in ~~(7)~~(8)(e) of this subsection shall be listed in total, not on a per thousand nor per unit basis. If more than one insured is covered under one policy or rider, guaranteed death benefits shall be displayed separately for each insured or for each class of insured if death benefits do not differ within the class. Zero amounts shall be displayed as zero and shall not be displayed as a blank space.

E. Disclosure requirements.

1. The insurer shall provide, to all prospective purchasers, a Buyer's Guide and a Policy Summary ~~prior to~~ before accepting the applicant's initial premium or premium deposit, unless the policy for which application is made contains an unconditional refund provision of at least 10 days or unless the Policy Summary contains ~~such~~ an unconditional refund offer, in ~~which~~ that event the Buyer's Guide and Policy Summary ~~must~~ shall be delivered with the policy or ~~prior to~~ before delivery of the policy.
2. The insurer shall provide a Buyer's Guide and a Policy Summary to any prospective purchaser upon request.

3. ~~In the case of policies whose~~ If the Equivalent Level Death ~~Benefits do~~ Benefit of a policy does not exceed $5,000, the requirement for providing a Policy Summary ~~will be~~ is satisfied by delivery of a written statement containing the information described in ~~subsection (D), paragraph (7), subparagraphs (b)~~ subsections (D)(8)(b), (c), (d), (e)(i) through (e)(iii), (f), (g), (j), and (k).

F. General rules

1. Each insurer shall maintain at its home office or principal office for at least three years after last authorized use a ~~complete file containing one~~ copy of each ~~document authorized by the insurer~~ form the insurer authorized for use ~~pursuant to this rule. Such file shall contain one copy of each authorized form for a period of three years following the date of its last authorized use~~.
2. ~~An agent~~ A producer shall inform the prospective purchaser, ~~prior to~~ before commencing a life insurance sales presentation, that ~~he~~ the producer is acting as a life insurance ~~agent~~ producer and inform the prospective purchaser of the full name of the insurance company ~~which he~~ that the producer is representing to the buyer. ~~In sales situations in which an agent is not involved~~ If an insurance producer is not involved in the sale, the insurer shall identify its full name.
3. ~~Terms~~ An insurer shall not use terms such as financial planner, investment advisor, financial consultant, or financial ~~counselling shall not be used in such a way as~~ counseling to imply that the insurance ~~agent~~ producer is generally engaged in an advisory business in which compensation is unrelated to sales unless ~~such~~ that is actually the case.

4. ~~Any reference to~~ If an insurer refers to policy dividends, the reference ~~must~~ shall include a statement that dividends are not guaranteed.

5. ~~A~~ An insurer shall not use a system or presentation ~~which~~ that does not recognize the time value of money through the use of appropriate interest adjustments ~~shall not be used~~ for comparing the cost of two or more life insurance policies. ~~Such~~ An insurer may use such a system or presentation to demonstrate ~~may be used for the purpose of demonstrating~~ the cash flow pattern of a policy if ~~such~~ the presentation is accompanied by a statement disclosing that the presentation does not recognize that, because of interest, a dollar in the future has less value than a dollar today.

6. ~~A~~ In a presentation of benefits, an insurer shall not display guaranteed and non-guaranteed benefits as a single sum ~~unless they are shown separately in close proximity thereto~~.

7. ~~A~~ An insurer shall include with a statement regarding the use of the Life Insurance Cost Indexes ~~shall include~~ an explanation ~~to the effect~~ that the indexes are useful only for the comparison of the relative costs of two or more similar policies.

8. ~~A~~ An insurer shall include with a Life Insurance Cost Index ~~which~~ that reflects dividends or an Equivalent Level Annual Dividend ~~shall be accompanied by~~ a statement that it is based on the company's current dividend scale and is not guaranteed.

9. ~~For the purposes of this rule, the annual premium for a basic policy or rider, for which the company reserves the right to change the premium, shall be the~~

~~maximum annual premium.~~ If an insurer reserves the right to change the premium for a basic policy or rider, the annual premium shall be the maximum annual premium.

G. ~~Failure to comply. Failure of an insurer~~ An insurer's failure to provide or deliver a Buyer's Guide, or a Policy Summary as provided in subsection (E) ~~shall constitute~~ constitutes an omission ~~which~~ that misrepresents the benefits, advantages, conditions, or terms of an insurance policy.

~~H. Effective date. This rule shall become effective immediately upon a certified copy of the same being filed in the Office of the Secretary of State of the State of Arizona but not before January 1, 1979.~~

APPENDIX

Life Insurance Buyer's Guide

The face page of the Buyer's Guide shall read as follows:

Life Insurance Buyer's Guide

This guide can show you how to save money when you shop for life insurance. It helps you to:

- Decide how much life insurance you should buy,

- Decide what kind of life insurance policy you need, and

- Compare the cost of similar life insurance policies.

Prepared by the National Association of Insurance Commissioners

Reprinted by (Company Name)

(Month and year of printing)

The Buyer's Guide shall contain the following language at the bottom of page 2:

The National Association of Insurance Commissioners is an association of state insurance regulatory officials. This association helps the various Insurance Departments to coordinate insurance laws for the benefit of all consumers. You are urged to use this Guide in making a life insurance purchase.

Buying Life Insurance

When you buy life insurance, you want a policy ~~which~~ that fits your needs without costing too much. Your first step is to decide how much you need, how much you can afford to pay and the kind of policy you want. Then, find out what various companies charge for that kind of policy. You can find important differences in the cost of life insurance by using the life insurance cost indexes ~~which~~ that are described in this guide. A good life insurance ~~agent~~ producer or company will be able and willing to help you with each of these shopping steps.

If you are going to make a good choice when you buy life insurance, you need to understand what kinds are available. If one kind does not seem to fit your needs, ask about the other kinds ~~which~~ that are described in this guide. If you feel that you need more information than is given here, you may want to check with a life insurance ~~agent~~ producer or company or books on life insurance in your public library.

This guide does not endorse any company or policy.

The remaining text of the buyer's guide shall begin on page 3 as follows:

Choosing the Amount

One way to decide how much life insurance you need is to figure how much cash and income your dependents would need if you were to die. You should think of life insurance as a source of cash needed for expenses of final illnesses, paying taxes, mortgages or other debts. It can also provide income for your family's living expenses, educational costs and other future expenses. Your new policy should come as close as you can afford to making up the difference between (1) what your dependents would have if you were to die now, and (2) what they would actually need.

Choosing the Right Kind

All life insurance policies agree to pay an amount of money if you die. But all policies are not the same. There are three basic kinds of life insurance.

1. Term insurance
2. Whole life insurance
3. Endowment insurance

Remember, no matter how fancy the policy title or sales presentation might appear, all life insurance policies contain one or more of the three basic kinds. If you are confused about a policy that sounds complicated, ask the ~~agent~~ producer or company if it combines more than one kind of life insurance. The following is a brief description of the three basic kinds:

Term Insurance

Term insurance is death protection of a "term" of one or more years. Death benefits will be paid only if you die within that term of years. Term insurance generally provides the largest immediate death protection for your premium dollar.

Some term insurance policies are "renewable" for one or more additional terms even if your health has changed. Each time you renew the policy for a new term, premiums will be higher. You should check the premiums at older ages and the length of time the policy can be continued.

Some term insurance policies are also "convertible." This means that before the end of the conversion period, you may trade the term policy for a whole life or endowment insurance policy even if you are not in good health. Premiums for the new policy will be higher than you have been paying for the term insurance.

Whole Life Insurance

Whole life insurance gives death protection for as long as you live. The most common type is called "straight life" or "ordinary life" insurance, for which you pay the same premiums for as long as you live. These premiums can be several times higher than you would pay initially for the same amount of term insurance. But they are smaller than the premiums you would eventually pay if you were to keep renewing a term insurance policy until your later years.

Some whole life policies let you pay premiums for a shorter period such as 20 years, or until age 65. Premiums for these policies are higher than for ordinary life insurance since the premium payments are squeezed into a shorter period.

Although you pay higher premiums, to begin with, for whole life insurance than for term insurance, whole life insurance policies develop "cash values" which you may have if you stop paying premiums. You can generally either take the cash, or use it to buy some continuing insurance protection. Technically speaking, these values are called

"nonforfeiture benefits." This refers to benefits you do not lose (or "forfeit") when you stop paying premiums. The amount of these benefits depends on the kind of policy you have, its size, and how long you have owned it.

A policy with cash values may also be used as collateral for a loan. If you borrow from the life insurance company, the rate of interest is shown in your policy. Any money ~~which~~ that you owe on a policy loan would be deducted from the benefits if you were to die, or from the cash value if you were to stop paying premiums.

Endowment Insurance

An endowment insurance policy pays a sum or income to you - the policyholder - if you live to a certain age. If you were to die before then, the death benefit would be paid to your beneficiary. Premiums and cash values for endowment insurance are higher than the same amount of whole life insurance. Thus endowment insurance gives you the least amount of death protection for your premium dollar.

Finding a Low Cost Policy

After you have decided which kind of life insurance fits your needs, look for a good buy. Your chances of finding a good buy are better if you use two types of index numbers that have been developed to aid in shopping for life insurance. One is called the "Surrender Cost Index" and the other is the "Net Payment Cost Index." It will be worth your time to try to understand how these indexes are used, but in any event, use them only for comparing the relative costs of similar policies. LOOK FOR POLICIES WITH LOW COST INDEX NUMBERS.

What is Cost?

"Cost" is the difference between what you pay and what you get back. If you pay a premium for life insurance and get nothing back, your cost for the death protection is the premium. If you pay a premium and get something back later on, such as a cash value, your cost is smaller than the premium.

The cost of some policies can also be reduced by dividends; these are called "participating" policies. Companies may tell you what their current dividends are, but the size of future dividends is unknown today and cannot be guaranteed. Dividends actually paid are set each year by the company.

Some policies do not pay dividends. These are called "guaranteed cost" or "non participating" policies. Every feature of a guaranteed cost policy is fixed so that you know in advance what your future cost will be.

The premiums and cash values of a participating policy are guaranteed, but the dividends are not. Premiums for participating policies are typically higher than for guaranteed cost policies, but the cost to you may be higher or lower, depending on the dividends actually paid.

What Are Cost Indexes?

In order to compare the cost of policies, you need to look at:

1. Premiums
2. Cash values
3. Dividends

Cost indexes use one or more of these factors to give you a convenient way to compare relative costs of similar policies. When you compare costs, an adjustment must be made

to take into account that money is paid and received at different times. It is not enough to just add up the premiums you will pay and subtract the cash values and dividends you expect to get back. These indexes take care of the arithmetic for you. Instead of having to add, subtract, multiply and divide many numbers yourself, you just compare the index numbers which you can get from life insurance ~~agents~~ producers and companies:

1. Life Insurance Surrender Cost Index. This index is useful if you consider the level of the cash values to be of primary importance to you. It helps you compare costs if at some future point in time, such as 10 or 20 years, you were to surrender the policy and take its cash value.

Life Insurance Net Payment Cost Index. This Index is useful if your main concern is the benefits that are to be paid at your death and if the level of cash values is of secondary importance to you. It helps you compare costs at some future point in time, such as 10 or 20 years, if you continue paying premiums on your policy and do not take its cash value.

There is another number called the Equivalent Level Annual Dividend. It shows the part dividends play in determining the cost index of a participating policy. Adding a policy's Equivalent Level Annual Dividend to its cost index allows you to compare total costs of similar policies before deducting dividends. However, if you make any cost comparisons of a participating policy with a non participating policy, remember that the total cost of the participating policy will be reduced by dividends, but the cost of the non participating policy will not change.

How Do I Use Cost Indexes?

The most important thing to remember when using cost indexes is that a policy with a small index number is generally a better buy than a comparable policy with a larger index number. The following rules are also important:

(1) Cost comparisons should only be made between similar plans of life insurance. Similar plans are those which provide essentially the same basic benefits and require premium payments for approximately the same period of time. The closer policies are to being identical, the more reliable the cost comparison will be.

(2) Compare index numbers only for the kind of policy, for your age and for the amount you intend to buy. Since no one company offers the lowest cost for all types of insurance at all ages and for all amounts of insurance, it is important that you get the indexes for the actual policy, age and amount which you intend to buy. Just because a "Shopper's Guide" tells you that one company's policy is a good buy for a particular age and amount, you should not assume that all of that company's policies are equally good buys.

(3) Small differences in index numbers could be offset by other policy features, or differences in the quality of service you may expect from the company or its ~~agent~~ producer. Therefore, when you find small differences in cost indexes, your choice should be based on something other than cost.

(4) In any event, you will need other information on which to base your purchase decision. Be sure you can afford the premiums, and that you understand its cash values, dividends and death benefits. You should also make a judgment on how well the life insurance company or ~~agent~~ producer will provide service in the future, to you as a policyholder.

(5) These life insurance cost indexes apply to new policies and should not be used to determine whether you should drop a policy you have already owned for awhile, in favor of a new one. If such a replacement is suggested, you should ask for information from the company ~~which~~ that issued the old policy before you take action.

Important Things To Remember - A Summary

The first decision you must make when buying a life insurance policy is choosing a policy whose benefits and premiums must closely meet your needs and ability to pay. Next, find a policy which is also a relatively good buy. If you compare Surrender Cost Indexes and Net Payment Cost Indexes of similar competing policies, your chances of finding a relatively good buy will be better than if you do not shop. REMEMBER, LOOK FOR POLICIES WITH LOWER COST INDEX NUMBERS. A good life insurance ~~agent~~ producer can help you to choose the amount of life insurance and kind of policy you want and will give you cost indexes so that you make cost comparisons of similar policies.

Don't buy life insurance unless you intend to stick with it. A policy which is a good buy when held for 20 years can be very costly if you quit during the early years of the policy. If you surrender such a policy during the first few years, you may get little or nothing back and much of your premium may have been used for company expenses.

Read your new policy carefully, and ask the ~~agent~~ producer or company for an explanation of anything you do not understand. Whatever you decide now, it is important to review your life insurance program every few years to keep up with changes in your income and responsibilities.

~~R20-6-212.~~R20-6-210. Readable and Understandable Policy: Private Passenger Automobile, Homeowner, Personal Line Dwelling, and Mobile Homeowner

~~**A.** Authority. This rule is adopted and promulgated by the Director of Insurance pursuant to A.R.S. §§ 20-142, 20-143, 20-441 through 20-460, 20-1110, 20-1110.01 and 20-1111.~~

~~**B.** Purpose. The purpose of this rule is to provide an orderly procedure for complying with the provisions of A.R.S. § 20-1110.01.~~

~~**C.**__**A.**__ Definitions. ~~As used~~ The following definitions apply in this ~~rule, unless the context otherwise requires~~ Section:

1. ~~A "readable~~ "Readable insurance policy" ~~is~~ means a ~~contract~~ policy ~~designed to~~ that can be read and reasonably understood by a person without special knowledge or training.
2. "Policy" means contract or agreement for ~~or effecting~~ insurance, or ~~the~~ an insurance certificate ~~thereof~~, by whatever name called, and includes all clauses, ~~riders,~~ endorsements and papers attached ~~thereto and a part thereof~~ or incorporated.

~~**D.**__**B.**__ Scope.

~~1.~~ This ~~rule~~ Section applies to ~~individual and personal line~~ private passenger ~~automobile~~ motor vehicle policies, homeowner policies, ~~and individual and~~ personal line dwelling policies, for ~~(4~~ four family units or less~~)~~, and mobile homeowner policies delivered or issued for delivery in Arizona ~~or~~

~~amended on or after January 1, 1979~~. ~~This rule shall not apply to any such dwelling policy covering a mobile home until after December 31, 1979~~.

~~2. This rule applies to individual and personal line automobile policies and individual and personal line dwelling policies (4 family units or less) that are renewed on or after January 1, 1982.~~

~~3. The Director reserves the right to extend the scope of this rule to other kinds of insurance in the future.~~

~~E.~~**C.** Compliance.

1. ~~Each~~ An insurer ~~is required to~~ shall test the readability of its policy by use of the Flesch Readability Formula as set forth in Rudolf Flesch, The Art of Readable Writing (1949, as revised 1974).

2. ~~A~~ An insurer's policy shall have a total readability score of 40 or more on the Flesch scale ~~is required~~.

3. ~~All policies, outlines of coverage or brochures within the scope of this rule shall be filed with the Director accompanied by a sworn affidavit setting forth the Flesch score and a sworn statement of compliance with the guidelines set forth in this rule.~~ An insurer shall include with each policy form filing required to be filed with the Director a checklist for the line of insurance setting forth the Flesch score.

~~F. Readable policy guidelines~~

D. Readability guidelines

~~1. The policy as a legal document. Revision of the insurance policy to make it more readable must not lead to its devaluation as a legal document. The policy must comply with all statutory and regulatory requirements.~~

~~2. Arizona standard fire policy. A.R.S. § 20-1110.01 modifies the provisions of Article 7, Chapter 6, Title 20, Arizona Revised Statutes, relating to the Arizona standard fire policy. All policies within the scope of the rule, including any policy that contains, in whole or in part, the provisions of the Arizona standard fire policy, shall comply with all requirements of this rule.~~

~~3~~1. General organization of text.

a. A readable policy shall be divided into logically arranged sections for ease of locating desired content.

b. Each section shall be self-contained as to provisions relating solely to that section.

c. General policy provisions applying to all or several coverages alike shall be located in a common area.

d. Non-essential provisions shall be eliminated.

e. Defined words and terms shall be ~~selected with care and placed in a separate definition section to appear early in the~~ placed in a section at the beginning of the policy ~~format~~.

~~4~~2. Visual aids to readability. The insurer shall ensure that each policy meets the following format requirements:

a. Type size shall ~~not~~ be ~~smaller than 8~~ at least eight point ~~and type style shall be selected with legibility as the primary consideration.~~

b. The font shall be block print rather than script, and legible.

~~b.~~c. Captions and headings shall be ~~clearly~~ distinguishable from the general text.

~~c.~~d. White space separating coverages, policy sections, and columns shall be sufficient to make a distinct separation.

~~d.~~e. Defined words and terms shall be ~~clearly~~ distinguishable from the general text.

~~5~~3. Language usage ~~suggestions~~. The insurer shall ensure that each policy:

a. ~~The policy should be~~ Is written in everyday, conversational language~~.~~;

b. ~~Use~~ Uses short, simple sentences and words in common usage ~~wherever possible~~.

c. ~~Use~~ Uses a personal style, personal pronouns, and present tense~~,~~ active verbs~~, wherever possible~~.

~~**G.** Outline of coverage. The requirements for a readable insurance policy contained in this rule may be complied with by an insurer providing to the policyholder an outline of coverage or brochure which accompanies the policy. Such an outline of coverage or brochure must comply with the readability requirements contained in this rule for a policy. If an insurer elects to use such an outline of coverage or brochure, the policy that is provided to the policyholder and accompanied with the outline of coverage or brochure need not comply with the readability requirements of this rule. If an insurer~~

~~elects to use such an outline of coverage or brochure, the outline of coverage or brochure must contain all provisions of the policy.~~

~~**H.** This rule shall become effective immediately upon a certified copy of the same being filed in the Office of the Secretary of State of the State of Arizona.~~

~~R20-6-213.~~R20-6-211. ~~Unfair~~ Discrimination on the Basis of Blindness, Partial Blindness

~~**A.** Authority. This rule is adopted pursuant to A.R.S. §§ 20-142, 20-143, 20-441 through 20-460, 20-1110 and 20-1111.~~

~~**B.** Purpose. The purpose of this rule is to ensure that individuals who are blind, partially blind, or have a physical disability will not be unfairly discriminated against in the rates charged for or the availability of any contract of life insurance or life annuity or in the dividends or other benefits payable thereon or in any other of the terms and conditions of such contract; and will not be unfairly discriminated against in the amount of premium, policy fees or rates charged for or the availability of any policy or contract of insurance other than life or in the benefits payable thereunder or in any of the terms or conditions of such contract, or in any manner whatever.~~

~~C~~A. Definitions. The following definitions apply in this Section:

1. ~~"Contract"~~ "Policy" means any ~~policy of~~ contract or agreement for or effecting insurance, or ~~the~~ a certificate ~~thereof~~ of insurance, by whatever name called, and includes all clauses, riders, endorsements and attached papers ~~attached thereto and a part thereof~~.

2. "Person" ~~shall mean "person" as defined~~ has the same meaning prescribed in A.R.S. § 20-105.

~~D.~~B. Scope. This ~~rule shall apply~~ Section applies to all ~~contracts~~ policies delivered or issued for delivery in this state ~~by a person on or after the effective date of this rule. This rule shall also apply to any group or blanket contract which has been delivered or issued for delivery in this state before the effective date of this rule, but not until such contract is amended or renewed at or after the later of the following times:~~

~~1. The effective date of this rule, or~~

~~2. If the contract provides benefits in connection with or pursuant to the provisions of a collective bargaining agreement which is in force on the effective date of this rule, when such collective bargaining agreement expires~~.

~~E.~~C. Prohibition. The following ~~are hereby identified as~~ acts or practices ~~which~~ constitute unfair discrimination between individuals of the same class and are prohibited:

1. Refusing to insure, or refusing to continue to insure, or limiting the amount, extent or kind of coverage available to an individual solely because of blindness or partial blindness~~,~~; or ~~charging~~

2. Charging an individual a different rate for the same coverage solely because of blindness or partial blindness.

~~F.~~D. As used in this subsection, ~~Refusal~~ "refusal to insure" includes denial by an insurer of disability insurance coverage on the grounds that the policy defines

"disability" as being presumed ~~in the event that~~ if the insured loses ~~his/her~~ eyesight. ~~However, an~~ An insurer may exclude from coverage disabilities~~,~~ consisting solely of blindness or partial blindness~~, when such condition existed at the time~~ if the insured was blind or partially blind when the policy was issued.

~~G.~~**E.** ~~With respect to~~ For all other conditions, including the underlying cause of the blindness or partial blindness, ~~persons who are~~ a person who is blind or partially blind ~~shall be~~ is subject to the same standards of sound actuarial principles or actual or reasonably anticipated experience as ~~are~~ a sighted ~~persons~~ person.

~~R20-6-215.~~R20-6-212. Forms for Replacement of Life Insurance Policies and Annuities

The Department adopts, incorporates, and approves as its own the following forms of the National Association of Insurance Commissioners Model Regulations (and no future editions or amendments), which are incorporated by reference~~, on file with the Office of Secretary of State,~~ and ~~copies~~ available ~~from~~ at the Department of Insurance, 2910 North 44th Street, Phoenix, Arizona 85018 and the National Association of Insurance Commissioners, Publications Department, 2301 McGee St., Suite 800, Kansas City, MO 64108:

1. For the purpose of meeting the requirements of A.R.S. § 20-1241.03(C): Life Insurance and Annuities Replacement Model Regulation, Appendix A - Important Notice: Replacement of Life Insurance or Annuities, Volume III, pp. 613-11 through 613-12, July 2000.

2. For the purpose of meeting the requirements of A.R.S. § 20-1241.07(A): Life Insurance and Annuities Replacement Model Regulation, Appendix B - Notice Regarding Replacement: Replacing Your Life Insurance Policy or Annuity?, Volume III, pp. 613-13, July 2000.
3. For the purpose of meeting the requirements of A.R.S. § 20-1241.07(B)(2): Life Insurance and Annuities Replacement Model Regulation, Appendix C - Important Notice: Replacement of Life Insurance or Annuities, Volume III, pp. 613-14 through 613-15, 1998.

~~R20-6-215.01.~~R20-6-212.01. Forms for Buyer's Guide for Annuities

The Department adopts, incorporates, and approves as its own the following forms of the National Association of Insurance Commissioners Model Regulations (and no future editions or amendments), which are incorporated by reference~~, on file with the Office of Secretary of State,~~ and ~~copies~~ available ~~from~~ at the Department of Insurance, 2910 North 44th Street, Phoenix, Arizona 85018 and the National Association of Insurance Commissioners, Publications Department, 2301 McGee St., Suite 800, Kansas City, MO 64108:

For the purpose of meeting the requirements of A.R.S. § 20-1242.02 regarding a Buyer's Guide: Annuity Disclosure Model Regulation, Appendix - Buyer's Guide to Fixed Deferred Annuities, Volume II, pp. 245-6 through 245-13, 1999, with attached Appendix I - Equity-Indexed Annuities, Volume II, pp. 245-14 through 245-20, 1999.

~~R20-6-216.~~R20-6-213. Life and Disability Insurance Policy Language Simplification

~~**A.** Authority. This rule is adopted and promulgated by the Director of Insurance pursuant to A.R.S. §§ 20-142, 20-143, 20-441 through 20-460, 20-1110, 20-1110.01 and 20-1111.~~

~~**B.** Purpose. The purpose of this rule is to establish minimum standards for language used in policies, contracts and certificates of life insurance, disability insurance, credit life insurance and credit disability insurance delivered or issued for delivery in this state to facilitate ease of reading by insureds.~~

~~**C.**~~**A.** Definitions. ~~As used in this rule, unless the context otherwise requires~~ The following definitions apply in this Section:

1. "Company" or "insurer" means any life or disability insurance company, benefit insurer, benefit stock insurer, prepaid dental plan organizations, health care service organizations, and all similar type organizations.
2. "Director" means the Director of Insurance of Arizona.
3. "Policy" or "policy form" means any policy, contract, plan or agreement of life or disability insurance, including credit life insurance and credit disability insurance, delivered or issued for delivery in the state by any company subject to this rule; and any certificate issued ~~pursuant to~~ under a group insurance policy delivered or issued for delivery in this state.

~~**D.**~~**B.** Applicability.

~~1.~~ This ~~rule~~ Section and R20-6-212 ~~shall~~ apply to all life and disability insurance policies delivered or issued for delivery in this state by any company ~~on or after the date such forms must be approved under this rule, but nothing in this rule shall apply~~ but do not apply to:

a. Any policy ~~which~~ that is a security subject to federal jurisdiction;

b. Any group policy covering a group of 1,000 or more lives at date of issue, other than a group credit life insurance policy or a group credit disability insurance policy~~;~~ however, this shall not exempt any certificate issued ~~pursuant to~~ under a group policy delivered or issued for delivery in this state; or

c. Any group annuity contract ~~which~~ that serves as a funding vehicle for pension, profit-sharing, or deferred compensation plans;

~~d. Any form used in connection with, as a conversion from, as an addition to, or in exchange pursuant to a contractual provision for, a policy delivered or issued for delivery on a form approved or permitted to be issued prior to the dates such forms must be approved under this rule; or~~

~~e. The renewal of a policy delivered or issued for delivery prior to the dates such forms must be approved under this rule.~~

2. Except as provided in ~~A.C.R.R. R20-6-212~~ R20-6-210, no other rule of this state setting language simplification standards shall apply to any policy forms.

E. Minimum policy language simplification standards.

1. In addition to any other requirements of law, ~~no~~ a policy ~~forms~~ form, except as stated in subsection (D), shall not be delivered or issued for delivery in this state on or after the dates ~~such~~ the forms ~~must~~ shall be approved under this ~~rule~~ Section unless:

a. The text achieves a minimum score of 40 on the Flesch reading ease test or an equivalent score on any other comparable test as provided in ~~paragraph (3) of this subsection~~ (E)(3);

b. It is printed, except for specification pages, schedules and tables, in not less than 10 point type, one point leaded;

c. The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the text of the policy or to any endorsements or riders; and

d. It contains a table of contents or an index of the principal sections of the policy, if the policy has more than 3,000 words printed on ~~3~~ three or fewer pages of text, or if the policy has more than ~~3~~ three pages regardless of the number of words.

2. ~~For the purposes of this subsection, a~~ An insurer shall measure a Flesch reading ease test score ~~shall be measured by the following method~~ as follows:

a. For policy forms containing 10,000 words or less of text, an insurer shall analyze the entire form ~~shall be analyzed~~. For policy forms containing more than 10,000 words, an insurer may analyze the readability of two 200-word samples per page ~~may be analyzed~~ instead of the entire form. The ~~samples shall be separated~~ insurer shall separate the samples by at least 20 printed lines.

b. ~~The number of words and sentences in the text shall be counted and the total number of words divided by the total number of sentences. The figure obtained shall be multiplied~~ The insurer shall count the number of words and sentences in the text then divide the total number of words by the total number of sentences, then multiply that figure by a factor of 1.015.

c. ~~The total number of syllables shall be counted and divided by the total number of words. The figure obtained shall be multiplied~~ The insurer shall count and divide the total number of syllables by the total number of words, then multiply that figure by a factor of 84.6.

d. The sum of the figures computed under subsections (b) and (c) subtracted from 206.835 equals the Flesch reading ease score for the policy form.

e. For ~~purposes of subparagraphs~~ subsections (b), (c), and (d), the insurer shall use the following procedures ~~shall be used~~:

i. A contraction, hyphenated word, or numbers and letters, when separated by spaces, shall be counted as ~~1~~ one word~~,~~;

ii. A unit of words ending with a period, semicolon, or colon, but excluding headings and captions, shall be counted as a sentence, and

iii. A syllable means a unit of spoken language consisting of ~~1~~ one or more letters of a word as divided by an accepted dictionary. Where the dictionary shows ~~2~~ two or more equally acceptable pronunciations of a word, the pronunciation containing fewer syllables may be used.

f. The term "text" as used in this subsection shall include all printed matter except the following:

i. The name and address of the insurer~~;~~, the name, number or title of the policy, the table of contents or index, captions and subcaptions~~;~~, specification pages, schedules or tables; and

ii. ~~Any policy~~ Policy language ~~which is~~ drafted to conform to the requirements of ~~any~~ a federal law, regulation, or agency interpretation~~;~~, ~~any~~ policy language required by ~~any~~ a collectively bargained agreement~~;~~, ~~any~~ medical terminology, ~~any~~ words ~~which are~~ defined in the policy~~;~~,

and ~~any~~ policy language required by law or regulation~~;~~, provided~~, however,~~ the insurer identifies the language or terminology excepted by this ~~subdivision~~ subsection ~~(ii)~~ and certifies, in writing, that the language or terminology is entitled to be excepted by this ~~subdivision~~ subsection.

3. Any other reading test may be approved by the Director for use as an alternative to the Flesch reading test if it is comparable in result to the Flesch reading ease test.

4. Filings subject to this subsection shall be accompanied by a certificate signed by an officer of the insurer stating that it meets the minimum reading ease score on the test used or stating that the score is lower than the minimum required but should be approved ~~in accordance with~~ under subsection (G) of this ~~rule~~ Section. To confirm the accuracy of any certification, the Director may require the submission of further information to verify the certification in question.

5. At the option of the insurer, riders, endorsements, applications and other forms made a part of the policy may be scored as separate forms or as part of the policy with which they may be used.

~~**F.** Construction. Nothing in this rule shall be construed to negate any law of this state permitting the issuance of any policy form after it has been on file for the time period specified.~~

~~G~~**F.** ~~Powers of the Director~~. The Director may authorize a lower score than the Flesch reading ease score required in ~~subparagraph~~ subsection (E)(1)(a) ~~whenever, in his sole discretion, he finds that~~ if a lower score:

1. ~~Will provide~~ Provides a more accurate reflection of readability of a policy form;
2. Is warranted by the nature of a particular policy form or type or class of policy forms; or
3. Is caused by certain policy language ~~which is~~ drafted to conform to the requirements of any state law, regulation or agency interpretation.

~~**H.** Effective dates. Except as provided in subsection (D), this rule applies to all policy forms filed on or after January 1, 1982. No new policy form shall be delivered or issued for delivery in this state on or after January 1, 1982, unless it has been filed pursuant to A.R.S. § 20-1110 and is in compliance with this rule. All other policy forms which have been approved or permitted to be issued prior to January 1, 1982, shall meet the standards set by this rule by January 1, 1984.~~

~~R20-6-217.~~R20-6-214. ~~Expired~~ Coordination of Benefits

A. Applicability.

1. This ~~rule~~ Section applies to all group disability insurance policies, group subscriber contracts of hospital and medical service corporations and of health care services organizations, and group disability policies of benefit insurers, as well as such group type contracts as are not available to the general public and can be obtained and maintained only because of the covered person's membership in or connection with a particular organization or group ~~which~~ that contain a

coordination of benefits provision. Group type contracts answering this description are included whether denominated as "franchise" or "blanket" or some other designation.

2. This ~~rule~~ Section does not apply to:

a. Individual or family policies or individual or family subscriber contracts except as provided for in ~~paragraph~~ subsection (A)(1) ~~above.~~;

b. Group or group-type hospital indemnity benefits (written on a non-expense incurred basis) of $30 per day or less unless they are characterized as reimbursement type benefits but are designed or administered ~~so as~~ to give the insured the right to elect indemnity type benefits, ~~in lieu~~ instead of ~~such~~ the reimbursement type benefits, at time of claim~~.~~; or

c. School accident type coverages, written on either a blanket, group, or franchise basis.

B. Definitions.

1. "Allowable expense" means any necessary, reasonable and customary item of expense, at least a portion of which is covered under one or more of the plans covering the person for whom claim is made or service provided.

a. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered ~~shall be~~ is deemed to be both an allowable expense and a benefit paid.

b. A plan ~~which~~ that takes ~~"~~Medicare~~"~~ or similar government benefits into consideration when determining the application of its coordination of benefits provision does not expand the definition of an allowable expense.

2. "Claim determination period" means an appropriate period of time such as "calendar year" or "benefit period" as defined in the policy.

3. "Plan" within the coordination of benefits provisions of a group policy or subscriber contract means the types of coverage which the insurer may consider in determining whether overinsurance exists with respect to a specific claim.

4. "School accident type coverages" means coverage ~~covering~~ of grammar school and high school students for accidents only, including athletic injuries, either on a 24-hour basis or "to-and-from school," for which the parent pays the entire premium.

C. Order of benefit determination.

1. When a claim under a plan with a coordination of benefit provision involves another plan ~~which~~ that also has a coordination of benefit provision, the insurer shall order ~~of~~ benefit determination ~~shall be made~~ as follows:

a. The benefits of a plan that covers the person claiming benefits other than as a dependent shall be determined before those of the plan ~~which~~ that covers the person as a dependent.

b. The benefits of a plan of a parent whose birthday occurs earlier in a calendar year shall cover a dependent child before the benefits of a plan of a parent whose birthday occurs later in a calendar year.

2. The word "birthday" as used in this paragraph refers only to month and day in a calendar year, not the year in which the person was born.

c. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in ~~this~~ the following order~~;~~:

i. ~~first~~ First, the plan of the parent with custody of the child;

ii. ~~then~~ Then, the plan of the spouse of the parent with custody of the child; and

iii. ~~finally~~ Finally, the plan of the parent not having custody of the child.

d. Notwithstanding ~~paragraph~~ subsection (c) above, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first.

2. The benefits of a plan ~~which~~ that covers a person as an employee (or as that employee's dependent) are determined before those of a plan ~~which~~ that covers that person as a laid-off or retired employee (or as that employee's dependent). If the other plan does not have this provision and if, as a result, the plans do not agree on the order of benefits, this ~~paragraph shall not~~ subsection does apply.

3. If none of the provisions of subsection (C) determines the order of benefits, the benefits of the plan ~~which~~ that covered a claimant longer are determined before those of the plan ~~which~~ that covered that person for the shorter time.

4. If one of the plans is issued out of this state and determines the order of benefits based upon the gender of a parent and, as a result, the plans do not agree on the order of benefits, the plan with the gender rule shall determine the order of benefits.

D. Excess and other nonconforming provisions.

1. A plan with an order of benefit determination provision ~~which~~ that complies with this ~~rule, herein called~~ Section, a complying plan, may coordinate its benefits with a plan ~~which~~ that is "excess" or "always secondary" or ~~which~~ that uses an order-of-benefit determination provision ~~which~~ that is inconsistent with ~~that contained in~~ this ~~rule~~ Section, ~~herein called,~~ a noncomplying plan, on the following basis:

   a. If the complying plan is the primary plan, it shall pay or provide its benefits on a primary basis.

   b. If the complying plan is the secondary plan, it shall~~, nevertheless,~~ pay or provide its benefits first, as the secondary plan. ~~In such a situation, such~~ The payment shall be the limit of the complying plan's liability, except as provided in ~~subparagraph~~ subsection (d).

   c. If the noncomplying plan does not provide the information needed by the complying plan to determine its benefits within a reasonable time after it is requested to do so, the complying plan shall assume that the benefits of the noncomplying plan are identical to its own, and shall pay its benefits accordingly. ~~However, the~~ The complying plan ~~must~~ shall adjust any payments it makes based on ~~such~~ the assumption whether information becomes available as the actual benefits of the noncomplying plan.

d. If the noncomplying plan pays benefits so that the claimant receives less in benefits than ~~he or she~~ the claimant would have received had the noncomplying plan paid or provided its benefits as the primary plan, then the complying plan shall advance to or on behalf of the claimant an amount equal to ~~such~~ the difference. ~~which~~ The advance shall not include a right to reimbursement from the claimant.

~~**E.** Severability. If any provision of this rule or the application thereof to any person or circumstances is held invalid, the remainder of the rule and the application of such provision to other persons and circumstances shall not be affected.~~